Department of Health and Human Services

improving the health, safety, and well-being of America

2010 Tribal Consultation Report

Prepared by:

The Office of Intergovernmental Affairs

March 2011

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The Office of Intergovernmental Affairs

United States Department of Health and Human Services

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Department of Health and Human Services
Office of Intergovernmental Affairs

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Left to Right: ***Paul Dioguardi*** (Director, Intergovernmental Affairs), ***Yvette Roubideaux*** (Director, Indian Health Service), ***Ned Norris*** (Chairman, Tohono O'odham Nation), ***Jefferson Keel*** (President, National Congress of the American Indians), ***Secretary of Health Kathleen Sebelius***, ***Mark Macarro*** (President, Pechanga Tribe), ***Buford Rolin***, (Vice Chairman, National Indian Health Board), ***Theresa Two Bulls*** (President, Oglala Sioux Tribe), ***Laura Petrou*** (Chief of Staff, Office of Secretary Kathleen Sebelius

2010 EXECUTIVE SUMMARY

The U.S. Department of Health and Human Services (HHS) and Indian Tribes share the goals of eliminating health and human service disparities of Indians, ensuring maximum access to critical health and human services and advancing the social, physical, and economic status of Indians. To achieve these goals, federally-recognized Indian Tribes and HHS engage in open, continuous and meaningful consultation.

The 2010 Tribal Consultation Report provides a comprehensive summary of the Department's consultation efforts from October 1, 2009 through September 30, 2010. HHS's guiding policy, the Tribal Consultation Policy, was revised in 2010, and signed by Secretary Sebelius on December 14, 2010. This policy, as in previous versions, calls for the Department to measure and report the results and outcomes of its Tribal consultation performance to fulfill the government-to-government relationship with Indian Tribes. This report describes the significant progress that the Department has made over the last year and a half towards reshaping the way that work with Tribes is conducted.

On November 5, 2009, at the White House Tribal Nations Conference, President Barack Obama addressed leaders from more than 500 federally recognized tribes and reaffirmed his Administration's intent to forge a stronger, more equitable partnership with tribal nations. He issued a memorandum that called on every Cabinet agency to produce a plan that detailed the agency's full implementation of former President Clinton's Executive Order 13175 that established regular and meaningful consultation and collaboration between the federal government and tribal nations. A year later, on December 16, 2010, President Obama held a second conference, highlighting such successes as the United States support for the U.N. Declaration on the Rights of Indigenous Peoples and the passage of health care reform. The President described the benefits of the Affordable Care Act:

> *Now, last year, at this conference, tribal leaders talked about the need to improve the health care available to Native Americans, and to make quality insurance affordable to all Americans. And just a few months later, I signed health reform legislation into law, which permanently authorizes the Indian Health Care Improvement Act – permanently... It's going to make it possible for Indian tribes and tribal organizations to purchase health care for their employees, while making affordable coverage available to everybody, including those who use the Indian Health Service -- that's most American Indians and native -- Alaska Natives. So it's going to make a huge difference.*

At the 2010 White House Tribal Nations Conference, the President gave leaders from 565 federally recognized tribes the opportunity to interact directly with representatives from the highest levels of the Administration to have frank and open discussions about the challenges that persist as well as the accomplishments.

Under the leadership of Secretary Sebelius, the Department of Health and Human Services has been working hard to implement the landmark health care reform legislation, the Patient Protection and Affordable Care Act, which was passed on March 23, 2010. Many of the

provisions in the Affordable Care Act specifically reference tribes, urban Indian organizations, the Indian Health Service (IHS), or tribal and urban Indian health facilities. Tribes, as sovereign nations, have businesses, employ people, and administer health programs and grants, and, therefore, are among the primary beneficiaries of the insurance reforms, grant programs, and cost-saving measures of the Affordable Care Act. As part of the enactment of the Affordable Care Act, the Indian Health Care Improvement Act (IHCIA) was reauthorized.

The Department has prioritized consultations by operating divisions and regional offices around the Affordable Care Act, the Indian Health Care Improvement Act, and more. The Department has made key leaders accessible and available and has created and implemented new advisory structures and policies.

At the March 2, 2010, meeting of the National Congress on American Indians, Secretary Sebelius echoed the President's commitment to working closely with tribal nations:

> *As President Obama said at the Tribal Summit last November, Washington can't—and shouldn't—dictate a policy agenda for Indian Country. Working with the tribes is a priority for President Obama, as it is for the Department of Health and Human Services and every other cabinet agency. The only way tribal nations can serve people's needs is for you to set the vision. Then we can work with you to achieve it. . . We know the only way to achieve real progress in that effort is to work side by side with you.*

At this meeting, Secretary Sebelius pledged to form a Secretary's Tribal Advisory Committee and to revise the HHS Tribal Consultation Policy. The completion of these benchmarks, among others, is document in the report that follows.

The 2010 Tribal Consultation Report's format largely mirrors that of last year's. Feedback from tribal leadership indicates that this format is readable and accessible. The Office of Intergovernmental Affairs would be pleased to receive any feedback or suggestions you have on the report.

Section I: 2010 HHS Consultation Overview lists the consultation efforts of the HHS Office of the Secretary. It includes the 2010 Major Outcomes and Accomplishments, an overview of the 12th Annual HHS Tribal Budget Formulation and Policy Consultation and the 8th Annual HHS Regional Tribal Consultation Sessions.

Section II: Regional Offices lists the consultation efforts of HHS Regional Offices during the last year. In order to distinguish national from local or regional consultation efforts, this section is organized according to type of consultation, including Highlights of Region-Specific Accomplishments, Summary of 2010 Regional Consultation Sessions, Tribal Delegation Meetings, Regional Visits to Tribes and Tribal Summits. Information about the date(s), sponsoring region and a brief summary are included for each consultation activity. Regions have also been following up quarterly with their respective Tribes on issues identified at the annual regional consultations.

Section III: HHS Divisions lists the consultation efforts of HHS Operating Divisions during the last year. This section is organized by type of consultation, including Highlights of Division Specific Accomplishments/Activities Targeted towards AI/AN's, Division Specific Activities, Tribal Delegation Meetings, Workgroups/Task Force Meetings, and Tribal Summits. Information about the date(s), sponsoring division and a brief summary are included in each consultation activity.

Section IV: Intradepartmental Council on Native American Affairs (ICNAA) describes what the ICNAA is, how HHS responds to the ICNAA priorities and what the ICNAA has done in 2010.

Finally, the **Appendices** section offers a wealth of supportive information to maximize the use of the Report as a resource. Staff lists charts, maps, budget information and the HHS Tribal Consultation Policy as well as the Charter for the Secretary's Tribal Advisory committee and its members.

Please feel free to review this report online at our website: ***http://www.hhs.gov/ofta.***

2010 MAJOR HHS OUTCOMES AND ACCOMPLISHMENTS

Patient Protection and Affordable Care Act

On March 23, 2010 the Patient Protection and Affordable Care Act was passed. Tribes are among the primary beneficiaries of the insurance reforms, grant programs, and cost-saving measures of the Affordable Care Act. American Indians and Alaska Natives can continue to be eligible for and use Indian Health Service (IHS), Tribal, or urban Indian health programs, but if they want to, they will be able to purchase health insurance through the new health insurance exchanges, authorized in this bill, which should have more affordable options. If AI/AN individuals don't want to purchase health insurance, as long as they get their care through our I/T/U system, they won't have to pay a penalty. The expanded eligibility for Medicaid in the health reform bill will also likely help many patients in Indian Country.

Indian Health Care and Improvement Act

Along with the passage of the Patient Protection and Affordable Care Act, the Indian Health Care and Improvement Act was permanently reauthorized on March 23, 2010. This bill was first approved by Congress in 1976 and prior to this year's passage had not been updated or reauthorized by Congress. The bill permanently reauthorized the Indian Health Service. The bill is a critical step in modernizing the Indian health care system and improving access to health care for American Indians and Alaska Natives.

The Affordable Care Act Outreach Plan

The Office of Intergovernmental Affairs (IGA) developed an outreach plan to provide tribes with more information and opportunities to consult on the Affordable Care Act and the provisions that affected them as tribes and individuals. Each quarter, the Department will compile information on activities of the Department of Health and Human Services (HHS) relating to Indian Country and the Affordable Care Act. This quarterly report is intended to bring to the attention of tribes, tribal organizations, urban Indian organizations, and American Indian and Alaska Native (AI/AN) individuals and families important funding opportunities, consultation sessions, informational meetings, and other efforts relevant to tribal communities that have been implemented at HHS during this period. HHS also engages tribal partners in monthly conference calls, listening sessions, and weekly emails. It is our intention that this outreach effort will complement and enhance the interagency implementation effort and improve communication between the federal government and tribes.

HHS Tribal Consultation Policy

As part of the Department's efforts to implement all legislative mandates, as well as to respond to the President's memorandum of November 5, 2009, regarding tribal consultation policies at Executive Branch departments and agencies, Secretary Sebelius asked for a revised Tribal Consultation Policy (TCP). HHS completed eight regional consultation sessions in May 2010 and created a Tribal-Federal Work Group (TFWG) in July 2010 to review the reports of the regional sessions and revise the Department's TCP. The TFWG completed a revised draft policy. This draft HHS TCP was sent to Tribal leaders to seek their input on October 7, 2010. Secretary Sebelius signed the revised Tribal Consultation Policy on December 14, 2010, at the first convening of the Secretary's Tribal Advisory Committee (STAC).One of the changes found throughout the policy is that tribal input will be sought "throughout all stages" of the development of policies, regulations, and budgets. Another substantive change is the new requirements regarding HHS' duties in reviewing authorizing statutes and regulations to determine if Federal program funding must be distributed to States rather than directly to Tribes in all instances where this practice is

operating. In addition, references to non-Federally recognized groups of Indigenous people have been removed. The majority of revisions or additions to the policy were to clarify the roles and responsibilities of the Divisions in carrying out the policy.

Secretary's Tribal Advisory Committee (STAC)

As part of the Department's efforts to improve services, outreach, and consultation efforts with tribal partners and be responsive to the President's memorandum of November 5, 2009 regarding Tribal consultation, Secretary Sebelius requested that a Secretary's Tribal Advisory Committee be developed and convened. The establishment of a tribal advisory committee at the Secretarial level will create a coordinated, department-wide strategy to incorporate tribal guidance on HHS priorities, policies and budget, improve the Government-to-Government relationships, and mechanisms for continuous improvement with our services to Indian Tribes. On October 7, 2010, Secretary Sebelius announced the development of the STAC; on December 6, she announced the members of the Committee; and on December 13 & 14, the STAC was convened for the first time.

Administration for Children and Families (ACF) Tribal Consultation Policy

In August of 2010, ACF established a Tribal/Federal Workgroup made up of Tribal leaders and at-large members from within ACF's regional offices to develop an ACF Tribal Consultation Policy. The workgroup met several times and presented the draft policy for discussion this past September during the ACF Tribal Consultation Session. The draft policy was published in December 2010 for a 45 day comment period ending January 31, 2011. ACF is reconvening the workgroup March 7 & 8 to review the comments and revise the policy. In the spring of 2011, ACF anticipates publishing its final Tribal Consultation Policy. ACF will implement the policy immediately through a series of briefings to ensure ACF employees are aware of the policy and how consultation works.

HHS February 22, 2010 Plan to Implement the Presidential Memorandum on Tribal Consultation

On February 22, 2010, Secretary Sebelius submitted a letter to Office of Management and Budget (OMB) Director, Peter Orzag, that outlined a plan to be a leader within the Administration for Tribes and Tribal consultation and described the Department's compliance with Executive Order 13175. The letter focused on five primary ways that HHS would work to improve relationships with tribes: annual budget consultation, regional consultations, tribal delegation meetings, individual agency consultations and consultation policies and a written consultation report.

2010 Annual Tribal Budget and Policy Consultation

On March 4-5, 2010, HHS hosted the 12th Annual Department-wide Tribal Budget and Policy Consultation session in Washington, D.C. to facilitate FY 2012 budget recommendations. 183 tribal representatives and federal staff attended the two day session. Tribal representatives presented their priorities to senior leadership from HHS as well as to nine HHS agencies, including ACF, SAMHSA, CMS, CDC/ATSDR, NIH, AoA, AHRQ, and HRSA. Further discussion addressed both the IHS budget as well as cross-cutting issues including national health reform, the impact of state budget reductions in Indian Country, and wellness and prevention. Four main recommendations emerged, including providing block grant funds directly, coordinating efforts across HHS and with other federal agencies, increasing funding and increasing accessibility.

Regional Tribal Consultation Sessions

The HHS Regional Tribal Consultation Sessions are designed to solicit Tribes' priorities and needs on health and human services and programs. The Sessions provide an opportunity for Indian Tribes to articulate their comments and concerns on budgets, regulations, legislation and HHS health and human services policy matters. This year marks the 7th year of these consultation sessions in the field. Between March through May of 2010, HHS held eight regional tribal consultation sessions across the country with the goal of improving the HHS tribal consultation process, agency policies, and overall communication. Sessions were well-attended with over 200 of the federally recognized tribes participating.

National Congress of American Indians

On March 2, 2010, Secretary Sebelius addressed the National Congress of American Indians at their Tribal Nations Legislative Summit and Executive Council Winter Session, which brought together tribal leaders, national, regional and local tribal organizations. The meeting is the one time of year that NCAI, the oldest and largest organization of elected tribal leaders, is in Washington, DC.

Tribal Leaders Roundtable

On March 2, 2010, Secretary Sebelius held a tribal leaders roundtable at her office with elected tribal leaders from the Chickasaw Nation, Tohona O'Odham Nation, Poarch Creek Band of Creek Indians Pechanga Band of Luiseno Mission Indians, Oglala Sioux Tribe, Jamestown S'Klallam Tribe and the Tlingit and Haida Indian Tribe of Alaska. Discussion centered on government-to-government relationship, tribal consultation and the ways in which HHS can be helpful to advancing the needs of tribal communities across the country.

New Mexico Indian Country

On July 21st, 2010, Secretary Sebelius visited New Mexico Indian Country. At the Pueblo of Jemez, the Secretary received a tour of the Visitor's Center and engaged in a discussion with tribal leaders and children. The Secretary was then hosted at the Isleta Pueblo, lunched with Isleta Elders and visited children at the recreation center. Finally, the Secretary attended a discussion with tribal leaders at the Isleta Golf Course.

Tribal Leaders Meeting

On December 15, 2010, Secretary Sebelius attended President Obama's Tribal Leaders Meeting along with Secretary Salazar and Attorney General Holder. She gave an opening statement at the beginning of the meeting. The Tribal Leaders Meeting preceded the Tribal Nations Conference held each year in December at the White House.

270 Day Progress Report Toward Implementation of EO 13175

In August 2010, the Department of Health and Human Services submitted a progress report on tribal consultation activities in compliance with the President's memorandum of November 5, 2009 which instructed all agency and department heads to provide a status update within 270 days of progress towards implementation of Executive Order 13175, "Consultation and Coordination with Indian Tribal Governments." This report summarized the Department's progress towards the HHS plan that was submitted in February, 2010 to the director of the Office of Management and Budget.

12th ANNUAL NATIONAL HHS TRIBAL BUDGET AND POLICY CONSULTATION

On March 4-5, 2010, HHS hosted the 12th Annual Department-wide Tribal Budget and Policy Consultation session in Washington, D.C. 183 tribal representatives and federal staff attended the two day session. National tribal attendees included Jefferson Keel, National Congress of American Indians, and Reno Franklin, National Indian Health Board, as well as 30 Tribal Chairmen/Governors/Presidents and other elected officials.

Tribal representatives presented their priorities for the Department of Health and Human Services (HHS) to senior leadership. Tribal representatives also made presentations and engaged in dialogue around the budgets and policies of nine HHS agencies, including ACF, SAMHSA, CMS, CDC/ATSDR, NIH, AoA, AHRQ, and HRSA. On day two, tribal leaders and HHS representatives discussed the IHS budget as well as cross-cutting issues, including:

1. National Health Reform
2. Impact of State Budget Reductions in Indian Country
3. Wellness and Prevention

At the Budget Roundtable, Secretary Kathleen Sebelius swore in Lillian Sparks as the new Administrator for Native Americans at ACF. They were joined by Ellen Murray, Assistant Secretary for Financial Resources; Paul Dioguardi, Director, Intergovernmental Affairs; Yvette Roubideaux, Director, IHS; Pamela Hyde, Administrator, SAMHSA; Laura Petrou, Chief of Staff; Dora Hughes, Counselor to the Secretary; Rima Cohen, Counselor to the Secretary; Sharon Parrott, Counselor to the Secretary; and Richard Turman, Principal Deputy Assistant Secretary for Financial Resources.

In her remarks, Secretary Sebelius expressed the need to leverage resources across the Department and noted the President has asked the Administration's secretaries to coordinate activities as a Cabinet. While fiscal resources are limited, she noted that programs impacting AI/AN continue to be a priority. She noted, as a former Governor, she has appealed to her former colleagues to increase accessibility to state funds and programs for tribes. Finally, she spoke about the work group she will create to improve the HHS Tribal Consultation process.

FY 2012 Tribal Recommendations:

1. **Provide Block Grant Funds Directly:** Tribes expressed interest in receiving funding directly rather than as a pass-through from state and local governments, and emphasized H1N1 as a potent example of the limitations of the pass-through approach. Where there are statutory requirements that funding go through states, HHS could be more proactive in encouraging states to work with tribes to meet their needs.
2. **Coordinate Efforts Across HHS and with Other Federal Agencies:** Tribal leaders stressed the need to continue to look for opportunities to improve our coordination within HHS and with other federal agencies to improve access to our programs and make sure they are working for Native Americans.
3. **Increase Funding:** In general, tribal leaders requested funding increases for all programs affecting American Indians/Alaska Natives, citing the increasing cost of providing services and the Federal trust responsibility promised in treaties made with Native Americans.
4. **Increase Accessibility:** Tribal leaders recommended making available funding more accessible, whether through outreach and training to tribal applicants, reduced grant application and reporting requirements for tribal entities, or set-asides for tribes in state block grants.

2010 HHS REGIONAL CONSULTATION SUMMARY

The purpose of the Regional Tribal Consultations was to allow Tribal leaders to discuss programmatic issues, outreach efforts, and coordination issues at a more local level. As part of their discussions, they offered region-specific comments related to consultation issues, recommendations and requests. These comments, categorized by area, are presented below.

Regions 1, 2, 4 and 6 Consultation for United South and Eastern Tribes, Centers for Disease Control and Prevention, Atlanta, Georgia, March 30-31, 2010

Tribal leaders in Regions 1, 2, 4, and 6 requested that the use of breakout sessions not only continue, but that the length of time dedicated to breakout sessions is extended. They also argued that the emphasis of the consultation session needed to be more regionally focused; and they suggested that consideration be given to holding a combined consultation session for Eastern Tribes (perhaps every other year). There was a consensus among Tribes that a least one regional session per year was needed, but many felt that more frequent sessions were needed. As a supplement to face-to-face meetings, the implementation of quarterly conference calls and brief weekly updates from the regional offices to Tribes to improve accountability of the HHS Consultation Policy across the Department was recommended. Additionally, a comprehensive 6-month status report from the regional offices was requested.

Region 5 Bemidji Area Tribal Consultation, **Minneapolis Airport Marriott, Bloomington, Minnesota, April 20, 2010**

Tribal leaders at the Minnesota consultation requested that they be able to delegate the responsibility of participating in the consultation process to appointed staff, as they argued that the process was very time consuming and select staff often possessed first-hand knowledge of key issues. Additionally, they asked that Tribes be able to request one-on-one consultation, as some issues required more direct discussions.

Regions 6 and 7 Tribal Consultation, Indian Pueblo Cultural Center, Albuquerque, New Mexico, April 22, 2010

Tribal leaders at the New Mexico consultation disagreed with the decision to combine Regions 6 and 7 for their Regional Tribal Consultation. They maintained that regional consultations must take place in every region. By combining the regions, many said, Tribal leaders from Region 7 were unable to attend. In regards to the HHS Agency Tribal Consultation Policies, it was suggested that HHS review New Mexico's Tribal consultation law to see if it could be used as a template by agencies that do not currently have consultation frameworks in place. Questions offered for consideration in developing a template included the following:

1. What actions initiate consultation?
2. Who initiates consultation (and do Tribes have the prerogative to bring the Federal government to the table)?
3. How far in advance should notice be given prior to consultation?
4. What procedures should prompt consultation?
5. How long should a consultation last?
6. How should the consultation sessions be documented?

Region 8 Tribal Consultation, Denver, Colorado, May 5, 2010

At the Denver consultation, when Tribal leaders considered ways that HHS might improve its communication and outreach to Tribes regarding policy and program changes, they suggested that HHS coordinate with the National Congress of American Indians (NCAI) Annual Conference in October to meet with Tribal leaders. They also indicated that they wanted to see the Aberdeen Area Office participate in the consultations. Regarding consultation participation, it was requested that consultation activities in Region 8 be targeted towards Tribal leaders. It was recommended that regional sessions be held annually over 2-3 days, with breakout sessions that included all HHS agencies. Finally, it was requested that all HHS agencies go to Montana 6 months from the date of the Regional Consultation to meet with Tribes.

Region 9 Tribal Consultation for Arizona and Nevada Tribes, Sheraton Phoenix Downtown, Phoenix, Arizona, April 29, 2010

At the Arizona consultation, the Navajo Nation requested that HHS recognize the Nation as a single entity and designate it as its one region, i.e., a new region, which will serve the Navajo people and assure effective and efficient dialogue between Federal and Tribal governments. Additionally, Tribal leaders felt that the HHS National and Regional Consultation Sessions should continue to be held annually, consistent with the HHS Tribal Consultation Policy; and it was suggested that Regional Consultation Sessions begin in May of each year to allow time for budget and other administrative activities.

Region 9 Tribal Consultation for California and Nevada Tribes, Harrah's Rincon Resort, Valley Center, California, April 27, 2010

Tribal leaders at the San Diego consultation expressed frustration concerning a number of issues, as evidenced by the following noted comments:

- The Federal government hires people that know nothing about Tribes west of the Mississippi River.
- Region 9 staffs [who work with Tribes] need to attend the consultation to hear the problems expressed by Tribes.
- The Tribal TANF population is among the most underrepresented of Native people, but Tribes consistently get resistance from ACF.
- The Region 9 Year-End Report failed to include the issue of Medicaid optional benefits; and there is concern regarding the lack of reporting out on the issue.
- Tribes continue to have difficulty accessing block grant money in California.

In regards to the Secretary's Tribal Advisory Committee, Tribal leaders recommended that membership of the Committee include two members from California Tribes (north and south). Finally, concerning the HHS Regional Consultation Format, Tribal leaders suggested having biannual meetings (spring and fall); holding joint consultations over 3 to 4 days with HHS, CMS, and IHS to maximize participation; and splitting the time of the meeting to allow HHS to address Tribal leaders for half of the time and Tribal leaders to address HHS for the other half of the time.

Region 10 Tribal Consultation for Alaska Native Villages, **Clarion Suites Downtown, Anchorage, Alaska, March 25, 2010**

Alaska Tribes expressed appreciation for having their own consultation session, as Tribal leaders indicated that Alaska Tribes contend with issues that were sufficiently different than Tribes from other areas. They requested that Co-Signers, elected by the

229 Federally-recognized Tribes to represent Alaska, be recognized as having the authority to speak on behalf of Alaska Tribes. They also requested that email lists from the Alaska Federation of Natives' Human Resources Committee and the Bureau of Indian Affairs be used to facilitate communication with providers, in addition to the Alaska Native Health Board. Finally, it was noted that the use of breakout sessions as part of the consultation process was not warranted in Alaska, and therefore a general session format was preferred. Specifically, it was recommended that future sessions be structured according to agency issues.

Region 10 Tribal Consultation for the Pacific Northwest, **Westin Hotel, Seattle, Washington, March 23, 2010**

Similar to the concern expressed by Tribal leaders in Region 9 about working with the State of California, Tribal leaders at the Seattle, WA consultation also cited a lack of States' cooperation (e.g., Idaho and Oregon) in with working with Tribes in Region 10 that resulted in Tribes having difficulty getting money from their States. An official request was made for assistance in working with the State of Idaho to convene consultations. Tribal leaders suggested that HHS schedule a meeting with Tribal leaders prior to an Affiliated Tribes of Northwest Indians (ATNI) session as a measure of good faith. They also suggested having staff present at consultations that dealt with programs on a daily basis. To this end, they asked that HHS consider having a 2-day consultation with a ½ day dedicated to discussions with program staff.

United States Department of Health and Human Services

2010 Regional Office Reports

Figure: U.S. Department of Health and Human Services Regional Divisions and Indian Health Service Areas

HEALTH AND HUMAN SERVICES

Region 1: Boston (*Nashville IHS)*
Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Region 2: New York (*Nashville IHS)*
New Jersey, New York, Puerto Rico, Virgin Islands

Region 3: Philadelphia (*Nashville IHS)*
Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia

Region 4: Atlanta (*Nashville, Oklahoma IHS)*
Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee

Region 5: Chicago (*Bemidji IHS)*
Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin

Region 6: Dallas
(*Nashville, Oklahoma, Albuquerque IHS)*
Arkansas, Louisiana, New Mexico, Oklahoma, Texas

Region 7: Kansas City
(*Aberdeen and Oklahoma IHS)*
Iowa, Kansas, Missouri, Nebraska

Region 8: Denver
(*Aberdeen, Albuquerque, Billings, Phoenix IHS)*
Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming

Region 9: San Francisco
(California, Phoenix, Tucson, Navajo IHS)
Arizona, California, Hawaii, Nevada, American Samoa, Commonwealth of the Northern Mariana Islands, Federates States of Micronesia, Guam, Marshall Islands, and Republic of Palau

Region 10: Seattle
(*Alaska, Portland IHS)*
Alaska, Idaho, Oregon, Washington

INDIAN HEALTH SERVICE UNIT

Aberdeen IHS
North Dakota, South Dakota, Iowa, Nebraska

Bemidji IHS
Indiana, Minnesota, Michigan, Wisconsin

Oklahoma IHS
Oklahoma, Kansas, Texas

Nashville IHS
Southern and Eastern United States

Albuquerque IHS
New Mexico, Colorado, Texas

Billings IHS
Montana, Wyoming

Navajo IHS
Arizona, New Mexico, Utah

Phoenix IHS
Arizona, California, Nevada, Utah

California IHS
California, Hawaii

Alaska IHS

Portland IHS
Idaho, Oregon, Washington

United States Department of Health & Human Services
2010 Annual Tribal Consultation Report

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HIGHLIGHTS OF REGION SPECIFIC ACCOMPLISHMENTS

- RD Hager attended two State of Maine Health Director Meetings
- RD Hager convened 1st US DHHS Region I quarterly conference call meeting with Tribal leaders, health directors and HHS leadership.

SUMMARY OF REGIONAL CONSULTATION SESSIONS

2010 Regions I, II, IV and VI Tribal Consultation Session, Atlanta, Georgia, March 30, 2010

USDHHS Regions I, II, IV and VI participated in the annual Tribal Consultation

Administration on Aging (AoA)

Focused on reporting, funding opportunities and coordination with the OAA Title III programs in the states. Secured a $10,000 grant from the Rhode Island Department of Elderly Affairs to the Narragansett Indian Tribe for their congregate meal program.

Centers for Medicare and Medicaid Services (CMS)

Collaboration with the Boston Regional Office of Medicaid to focus on state consultation policies of the Recovery Act. Regional office met with four New England states and federally recognized tribes with a goal of developing formal policies for state-plan amendments.

Tribal/State issues and technical assistance

Regional Office provided facilitation and expert advice to tribes with regards to (1) Rhode Island Tribal FQHC payment, (2) Indian health provider licensing, (3) Medicare Secondary Payer and ESRD, (4) Medicare-Like Rates, (5) assistance with grant funding, (6) HITECH, and (7) Contract Health Services.

Office of Civil Rights (OCR)

Collaboration with Mohegan Tribe to (1) confirm whether HIPAA/HITECH applies to the tribes and (2) clarification of state Attorney General's HITECH authority over tribes. OCR provided technical assistance in interpreting various regulations and continues to assist the Mohegan Tribe to determine HITECH compliance.

Food and Drug Administration (FDA)

Continued communication via phone and email with Regional tribes to include: Eastern Pequot, Narragansett, Wampanoag Tribe of Gay Head, Golden Hill Paugussett and Hassanamisco (Nipmuc).

Developing Exposure Concentrations for Regional Cultural Tribal Risk Assessment, Penobscot River - part of a U.S. Environmental Protection Agency (EPA) initiative called Regional Applied Research Effort (RARE)

ATSDR Region I assisted in (1) the development of the Quality Assurance Project Plan, and (2) the investigation of contaminated resources (fish, turtles, ducks, and plants) amongst the Penobscot Indian Nation. This review is ongoing with further action recommendations for public health consultation.

National Tribal Science Council Meeting, Traverse City, MI, June 6-10, 2010

ATSDR Region I (1) conducted a training session on the ATSDR Brownfield/Land Reuse (BF/LR) Site Tool. (2) Facilitated discussion on "National Conversation on Public Health and Chemical Exposures" with a goal to develop an action plan to strengthen efforts to protect the public from harmful chemical exposures. Overall goals include enhancement of material and increased tribal member involvement.

Agency for Toxic Substances and Disease Registry site visit with Penobscot Indian Nation's Department of Natural Resources representative to Penobscot Nation, Oct. 2010

In conjunction with other federal agencies (EPA, U.S. Geological Service, and Bureau of Indian Affairs), this meeting discussed the initial findings from the public health findings of exposure to potentially contaminated consumptive products.

Passamaquoddy Pleasant Point Reservation, Indian Island, Maine, November 2010

RD Hager, IGA specialist, Regional Outreach specialist attended the Quarterly State of Maine Tribal Health Director's Meeting. Tribes in attendance included Aroostook Band of Micmac, Houlton Band of Maliseet, Passamaquoddy Indian Township, Passamaquoddy Pleasant Point and Penobscot Nation. Director Hager met with the Health Directors and Human Service Directors of the five Maine Tribes and provided updates for more than 20 people in attendance. Highlight concern included unresolved co-pay issues with

MaineCare and the ORD would facilitate CMS Central Office and MaineCare to resolve this issue. Director Hager led a National Prevention Strategy Engagement Session in order to better understand the Health Service Directors perspective on prevention programs and strategies important to the five Maine Tribes.

TRIBAL DELEGATION CONSULTATION

Passamaquoddy Indian Township Reservation, May 20, 2010

RD Director Hager, IGA specialist and Region I CMS Native American Contact (NAC) attended the Quarterly State of Maine Tribal Health Director's Meeting in Princeton, Maine. They met with Governor William Nicholas, Passamaquoddy Tribal Council Member Elizabeth Neptune and members from the Aroostook Band of Micmac, Houlton Band of Maliseet, Passamaquoddy Indian Township, Passamaquoddy Pleasant Point and Penobscot Nation. Other attendees included: MaineCare Services (State Medicaid). The goal of this meeting was to provide information regarding (1) the Affordable Care Act, and (2) the American Recovery and Reconciliation Act (Recovery Act) with focus on requirements for State Tribal consultation, exemptions from cost sharing and premiums for Native Americans.

TRIBAL SUMMITS

CMS / Massachusetts Executive Office of Elder Affairs / In-Service for Native American Elder Health, Boston, Massachusetts, April 2010

A representative of the Region I CMS Medicaid program branch met with the Senior Medicare Patrol (SMP) Integration Project with a goal of continued collaboration and consultation.

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HIGHLIGHTS OF REGION-SPECIFIC ACCOMPLISHMENTS

- Training for the Nashville North Area was held on August 12-13 at the Seneca Niagara Hotel Casino in Niagara Falls, New York. CMS Region II was the principal organizer and IHS moderated the training. Region II Director Torres provided an overview of the Affordable Care Act.
- Regional Tribal Working Group (RTWG) continues to foster a strong working relationship between OpDivs and StaffDivs and regional Tribes.

SUMMARY OF REGIONAL CONSULTATION SESSIONS

Region II Tribal Consultation, Atlanta, GA, March 30-31, 2010

The United South & Eastern Tribes (USET) and the U.S. Department of Health & Human Services hosted the annual combined Tribal consultation session. Region II was represented by four Tribal leaders from two Tribes, St. Regis Mohawk and the Seneca Nation of Indians.

This year the consultation session focused on discussing the HHS Tribal Consultation Policy and Format. To improve communication and outreach the Tribes suggested that HHS include in its correspondence more Tribal recipients. At the time of the consultation; news and information was typically sent mostly to Tribal chiefs exclusively. Tribal health directors believe that if they received HHS information they can assist in highlighting applicability to the Chiefs and encourage participation. Tribal health directors also suggested that to improve the consultation format, HHS can define mission and expected outcomes and share with the Tribes before the meeting date.

Again, regional Tribes reinstated last year's request: They would like to see that the federal government gives NYS detail guidelines about working with the Tribes. Tribes experience limited collaboration with the state when they attempt to apply for federal funds that come down through the state.

St. Regis Mohawk Tribe reported that there has been a rise in the cancer deaths. Although no formal study has been conducted, the Seneca Nation of Indians also agreed that they are experiencing more cancer deaths in their reservations. Tribal health directors claim that the number of deaths could be reduced if there were early detection and treatment programs in the reservation. For specialized services, tribal members have to leave the reservation and this can deter them from being compliant with preventive care and treatment.

St. Regis Mohawk Tribe continues to operate Partridge House, the only Native American inpatient program licensed through the Office of Alcohol and Substance Abuse Services (OASAS), equipped to address how addiction impacts native communities within and outside New York State. The fifty six day program provides a safe environment for adult women and men to examine the roots of addiction and their personal growth in early recovery. St. Regis Mohawk Tribe foresees the possibility of working with HUD to discuss the halfway house model.

TRIBAL DELEGATION MEETINGS

American Indian Community House (AICH), May 24, 2010

The AICH health director visited HHS Region II office and provided an overview of their programs and services.

American Indian Community House, June 2, 2010

The Office of Minority Health provided partial funding for AICH participation in the annual Region II-New Jersey Primary Care Conference.

American Indian Community House, July 2010

The Office of the Regional Director connected the AICH with the NYS Office of Children and Family Services to acquire a culturally sensitive video that assists in the outreach of the Native American people.

American Indian Community House, September 2010

The Office of the Regional Director matched the AICH with a local community health center that is committed to provide medical attention to the community house Tribal members.

REGIONAL VISITS TO TRIBES

July 2, 2010. RD Torres visited the American Indian Community House, an urban Indian program in New York City.

November 2, 2010. RD Torres hosted a second conference call with Tribal health directors to consult about the 2011 Tribal Consultation. In addition, the attendees discussed the ACA, Let's Move and the upcoming SAMHSA regional presence.

TRIBAL SUMMITS

Nashville North Area Training Session, Seneca Niagara Hotel Casino, Niagara Falls, New York, August 12-13, 2010

RD Torres participated in a two-day training session with CMS Regional and Central Office staff. CMS staff gave an overview of the Affordable Care Act, Medicare 101 and Medicare Updates, Medicaid and CHIP 101, CHIPRA & ARRA, and CMS resources. SAMSHA participated by presenting on behavioral health care and substance abuse. The New York City Department of Health provided a presentation on Medicaid eligibility. The Social Security Administration provided updates and IHS discussed the benefits of electronic health records. The training was very successful with over twenty- two attendees as well as 10 attendees on the phone. There was consensus that additional training would be useful as well as monthly meetings with the regional office. These meetings are expected to begin middle or late January of 2011.

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HIGHLIGHTS OF REGION-SPECIFIC ACCOMPLISHMENTS

- On November 18, 2010, the Office of the Regional Director convened an inaugural quarterly conference call with Tribal partners in Region I of US DHHS. The call included Tribal leaders, health directors and HHS leadership. Topics of interest included the upcoming tribal consultation and the planning for a suicide conference.

- Regional Health Administrator ***Cobb***, in concert with the ORD, facilitated the potential filling of the chief pharmacist position for the Porch Creek Band of Indians. The position had been vacant for several months. Porch Creek Health Director ***Candace Fayard*** identified the commissioned corps candidate and RADM Cobb worked with OASH to help facilitate the transfer. Fayard said that this would provide much needed relief for their strained budget.

- The Office of the Regional Director (ORD), and the operating and staff divisions of Region 4 continued constant communications with the tribes in the southeast throughout this year. Highlights of ongoing wider HHS Region 4 engagement and communication include:

Administration on Aging (AoA), Region 4

The AOA Regional Office conducts on-going technical assistance to the federally recognized tribes in Region IV. TA consists of directions on how best to coordinate Title III and Title VI programs and services. During 2010, the issues generally focused on funding opportunities and reporting. One tribe had specific issues relative to management and operation because of the frequent turnover of project directors for the nutrition program. The issues have since been resolved.

Centers for Medicare and Medicaid Services (CMS) Training for IHS Nashville Area South, Hollywood, Florida, July 28-29, 2010

This meeting overviewed Medicare, Medicaid, (including 1915 and 1115 waivers); the new legislation on CHIPRA and ARRA and the impact on AI/AN, Cross Border issues and Survey and Certification. The training was attended by representatives of 5 out of the 6 Tribes in Region 4 and this is the first time Tribes participated by WebEx. Tribal representatives attending the training sessions and CMS-IHS staff agreed that there is a need to hold more training/meetings that include IHS, CMS, Tribes and States.

Health Resource Services Administration (HRSA) Meeting, at the Centers for Disease Control and Prevention, Atlanta, Georgia, March 30, 2010

HHS Regions I, II, IV, and VI met to obtain input from tribal leaders as to how HHS can improve its tribal consultation policy. HRSA provided a brief overview of the agency and some of the programs of interest to the tribes, provided information about the National Health Service Corps (NHSC) Loan Repayment Program and other HRSA loan repayment and scholarship programs. HRSA also sent the Nashville Area Indian Health Service the regional NHSC point-of-contact in order to obtain additional information for how an IHS site could become a NHSC site.

Poach Creek Indians in Atmore, Alabama

The HRSA regional office recently provided information to the health administrator on how to become a National Health Service Corps site. A team is set up to complete the NHSC application and upon approval, will post physician vacancy for staff recruitment.

SUMMARY OF REGIONAL CONSULTATION SESSIONS

USDHHS Regions I, II, IV and VI Tribal Consultation, at the Centers for Disease, Control and Prevention, Atlanta, GA, March 30, 2010

New CDC Director ***Dr. Tom Frieden*** addressed the gathering and expressed his interest in a building on vibrant, effective relationship with the tribes.

Attendance included: (**FEDERAL)** RD ***Clara Cobb***, former IGA Deputy Director ***Anne Filipic***; IHS Area Director ***Richie Grinnell***; Principal Advisor for Tribal Affairs ***Stacey Ecoffey***; EO ***Karen Ashton, Lillian Sparks***, ACF commissioner; IGA Specialist ***Deric Gilliard***, ***Cristal Jones,*** Office of Civil Rights, ***Donna Philips***, Office of Family Planning, HRSA Administrator ***Lisa Mariani***, HRSA Deputy ***Natalie Perry***, ACF Administrator ***Carlis Williams***, ACF Deputy ***Ken Jackson***, ACF Emergency Preparedness officer ***Reginald Hammond***; ***Dr. Renard Murray***, CMS regional Administrator; ***Kenni Howard***, CMS tribal representative. ***Candice Jett,*** program specialist for Region IV OWH; ***Karen Jordan***, ORD administrative assistant; ***Ruth Walker***, ACF program manager and ***Tara Brown***, CDC, assistant project officer. **(TRIBAL)** ***Terry Sweat***, Seminole Tribe, ***Candace Fayard***, Porch Band of Creek Indians (PBCI), ***Buford Roland***, Porch Creek tribal chairman, ***Helen Hallman***, Poarch Creek Tribal Council; ***Jaime McGhee***, Poarch Creek Clinic Director; ***Denise Ward***, Miccosukee Tribe of Indians of Florida, ***Donita Stephens***, Mississippi Band of Choctaw Indians (MBCI), ***Tihtiyas "Dee" Sabattus***,

Interim THPS Director / Health Policy Analyst, United South and Eastern Tribes, Inc. (USET), (STATE) ***Karen Simon,*** Florida Department of Health.

2010 Tribal Issues and Recommendations:

The Choctaw Nation needs more flexibility with signing up members on Medicaid than the state currently allows the tribe.

Background: The state of Mississippi currently staffs the Mississippi Band of Choctaw Indians Nation with one Medicaid eligibility staff person to serve the entire reservation, which includes ten communities. One person registering new applicants one day per week for 10,000 citizens is inadequate.

Challenge: According to Choctaw Director of Financial Services ***Donita Stephens***, the state would not supply help unless the citizen was either pregnant, or a child, even though the tribe is willing to support funding for additional personnel. As a result, the clinic continues to lose patients because there are not adequate personnel to sign them up for services.

Next step/plan: Region IV CMS ***Mary R. Justis***, Chief of the Program Operations Branch, Division of Medicaid and Children's Health, committed to exploring possible solutions at the 2010 Joint Tribal Consultation.

Time Frame: CMS' Justis said she hopes to have a resolution to the issue before the 2011 consultation.

Payer of last resort

Background: Seminole went to Baltimore, IHS and regional office trying to get help to resolve a payer of last resort issue. After consulting with IHS and USET's Dee Sabattus, CMS changed its position 180 degrees, according to Seminole Administrative Services Director Terry Sweat. Sweat said it took 2.5 years to resolve the issue. The major problem: lack of understanding of issues between Baltimore and IHS. Also, state and local governments lack understanding of law and policy regarding federally recognized tribes.

Next Step/Plan: Overall, the Region IV Tribal Nations are seeking better, more precise, expeditious and direct communications from the department and consequently the region. A further theme is their desire for greater inclusion of their human service components into future communications as well as a greater role of human services at consultation. There is a desire by the Tribes for a greater frequency of consultation during the year whether in person, by phone or other technology. As for the annual session, they do not prefer the combined regional consultation format and feel the need for a greater emphasis on the relationship between tribes and their corresponding regional office. Region IV Tribes also feel that consultation would be enhanced by the involvement of more HHS "decision makers" and leaders. Lastly, tribal nations continue to look to the ORD for support and leadership on matters that involve the states. Many of the tribes expect the ORD's continued support for the tribe's efforts as they communicate and work with the respective states in which their reservations are located.

Next Step/Plan: The ORD began working towards the resolution of the tribes issue requests at and immediately following the 2010 Combined Regional Consultation. The ORD will continue to build on its relationship with tribes and their leaders to improve the health and human services provided to tribal citizens in 2010 and beyond.

Need for increased accountability for states.

Background: When ARRA funding was announced, the monies were awarded to the states and the states were "asked" to consider stimulus grants to the tribes. The tribes insist that as sovereign, independent governments, they should not be required to depend on the states to determine their funding.

Next Steps/Plan: IGA and IHS will explore the issue through a new committee. The hope is that a policy will be created that will mandate that the states share funding with the tribes.

Physician Retention

Background: Traditionally, reservations such as the Choctaw struggle with finding and hiring quality physicians for their rural populations for their Level IV trauma center. Consequently, Choctaw Financial Services Director ***Donita Stephens*** requested help in addressing the problem. HRSA Administrator ***Lisa Mariani*** exchanged business cards and suggested Donita call her. Mariani also shared information on the National Health Service.

Time frame: ***Lisa Mariani*** touched base with HRSA's Bureau of Clinician Recruitment and Service, then shared the contact information with Donita Stephens, as well as referred her to a regional contact for further assistance.

REGIONAL VISITS TO TRIBES

Catawba Indian Nation of Rock Hill, South Carolina, August 17, 2010

The ORD/RHA-led Region IV delegation visited the Catawba Indian Tribe for the first time in recent history. ***RD Cobb*** began the federal presentations by sharing an overview of her dual role as both the representative of Secretary Sebelius and also talked about her duties overseeing minority health, emergency preparedness, women's health, family planning, the MRC and HIV support. EO ***Ashton*** shared the mission of the Medical Reserve Corps. HRSA presented information on partnership and funding opportunities, including the National Health Service Corps and the IHS Service Unit eligibility for NHSC loan re-payer and scholar placement, 330 funding, and the Healthy Weight Collaborative. The tribe expressed interest in additional information on 330 funding, which was provided as follow-up. ACF's presentation was centered around disseminating information and making a power point presentation on all ACF's programs. As a result of this meeting the Tribe is aware of the various services and grants they are eligible for through ACF. CMS' ***Kenni Howard*** provided Medicare, Medicaid and CHIPRA overviews.

TRIBAL SUMMITS

No tribal summits occurred during this time frame.

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HIGHLIGHTS OF REGION – SPECIFIC ACCOMPLISHMENTS

HHS Region 5 Office (RO5) Tribal Educational Briefing/Indian Health Service (IHS) Partnership Meeting

The RD highlighted the Administration's commitment to tribal governments in opening the meeting, with almost 100 participants from HHS RO5 divisions, including Executive Staff. ***Dr. Kathleen Annette***, Acting Field Director, IHS, and ***Jenny Jenkins***, Acting Director, IHS – Bemidji Area Office, highlighting history (e.g., special government relationship with tribes), cultural issues, IHS role., Addressed issues/challenges including: Health IT, Health Disparities, Tribal Consultation/Partnership, Funding, Health Reform, Aging Population, and working better together to serve this population. Dr. Annette was briefed by the OIG/OEI Lead Analyst of the Sept. 2009 OEI study, "IHS Contract Health Services (CHS) Programs: Overpayments and Potential Cost Savings." As follow-up, Dr. Annette shared study findings/recommendations with IHS Area Directors, including tribes should work diligently to ensure that CHS charges are not above the Medicare rate; savings can be used for additional, needed CHS.

HHS RO5 Informational Meeting with Ho Chunk District Legislators, June 2010

Executive Officer ***Krohn*** convened a dialogue session for Ho Chunk District 5 Legislators, who represent approximately 3500 non-WI tribal members across the country, on HHS tribal programs and resources, with HHS Regional leadership from Administration for Children and Families, Centers for Medicare and Medicaid Services (CMS) and Health Resources Services Administration. A list of HHS grants to the Ho Chunk Nation was sent prior to the meeting. While pleased with permanent reauthorization of the Indian Healthcare Improvement Act, a legislator reiterated for top

officials that IHS funding should not be discretionary, but mandatory, per treaty responsibility. Follow-up included: CMS technical assistance (t/a) on maximizing Medicare reimbursement/cost reports; and, HRSA t/a on utilization of National Health Service Corps. That evening, EO Krohn participated in the Chicago-area Ho-Chunk Town hall, noting Affordable Care Act concerns for RD to address as guest speaker at August Town hall meeting. [*See Regional Visit to Tribes*]

HHS RO5 HHS/Tribal Workgroup, October 2010

In partnership with MAST, the 1st Regional/Tribal Workgroup meeting to address regional issues identified during the Region V Tribal Consultation. Representatives from each HHS Op/Div as well as Tribal representatives from each state and an urban program participated on the call. Each Op/Div provided progress reports on the regional issues specific to their programs. [*See Region Specific Issues under Summary of Regional Tribal Consultation Session below.]*

SUMMARY OF REGIONAL TRIBAL CONSULTATION SESSION

Region 5 Tribal Consultation Session, Bloomington, MN, April 2010

The purpose of the session was to meet with Area tribal elected officials for input on the national tribal consultation policy, including how to improve the policy, how to conduct consultation and the overall process for consultation, to ensure that Bemidji-Area tribes are actively involved in this process and national policy development. The session provided an opportunity for HHS leadership to dialogue with Area Tribes on issues and concerns, and develop an action plan to address these issues. Over 30 tribal officials from MI, MN and WI participated, as well as Teresa Nino of CMS, ***Dr. Mary Wakefield*** of HRSA, ***Lillian Sparks*** of ACF, ***Dr. Kathy Annette*** of IHS, ***Robert Logan*** of AoA, ***Stacey Ecoffey*** of IGA, and regional office staff. Tribes were pleased with the Administration's accomplishments to date, including the inclusion of the Indian Health Care Improvement Act in the Affordable Care Act, ARRA funding, and the proposed Secretary's Tribal Advisory Council (STAC). However, expressed concerns about many long-standing issues that have not been resolved. These include requests for direct funding as sovereign nations, increased funding to address unmet need/disparities, set-asides, and specific language in competitive grants. Tribes reiterated the need for HHS to break down silos in consultation, and to focus consultation on outcomes rather than just process.

Top 5 National Issues of Concern/recommendations

1. Consultation (Process/Reporting/STAC)
2. Increased Budget/Funding
3. Tribal Sovereignty, state/local government recognition of tribes as sovereign nations
4. Health Reform/Health IT
5. Native American Data Shortage

Top 5 Region Specific

1. Establish Bemidji Area Tribal Health Board
2. Improve Tribal collaboration with non-tribal organizations in the Region.
3. Facilitate improved communication between tribes and state/county governments including state compliance with the Indian Child Welfare Act.

4. Improve access to non-institutional, culturally competent, long-term care options for tribal members
5. Increase resources for substance abuse/behavioral health treatment for tribes.

MAST Collaboration. 1st quarterly MAST- HHS Workgroup, October 2010

RD Thomas and MAST Secretary ***Kathy Hughes*** convened the Tribal representatives from each state, as well as an urban program participated. RD Thomas continues to share key national/regional tribal announcements (including grant opportunities, conferences and meetings).

Midwest Alliance of Sovereign Tribes (MAST) Meeting, Mount Pleasant, Michigan, July 2010

RD Thomas participated in the MAST summer meeting discussing follow up from the Region 5 Tribal Consultation, including the draft HHS 2010 Reg. V Consultation Report Matrix, and working group with HHS and tribal representatives to address major issues raised during the consultation. [*See Summary of Regional Tribal Consultation Session]*

REGIONAL VISITS TO TRIBES

Chicago Urban Health Program, January 2010

RD Thomas and IHS Acting Bemidji Area Director ***Jenkins*** met with Chicago IHS Urban Health Program officials and toured the site. Officials highlighted the hiring of a full-time doctor, HIV/AIDS testing, diabetes/obesity/heart heath/smoking cessation activities, domestic violence project (1 of 2 urban programs nationally selected), and work toward dental and podiatry services.

Menominee Indian Tribe of Wisconsin, February 2010

RD Thomas and IHS Area Director ***Jenkins*** met with Menominee Indian Tribe of Wisconsin Assistant Health Administrator and toured the Menominee Tribal Clinic**.** They also met with the director of the Menominee treatment center. Topics discussed included an overview of services offered at the center such as addiction treatment, mental health services and domestic violence services. The center received ARRA funding, which was used to improve the domestic violence shelter and transitional housing.

Stockbridge-Munsee Band of Mohican (Wisconsin), February 2010

RD Thomas and IHS Area Director ***Jenkins*** met with ***Nancy Miller-Korth***, Health Director for the Stockbridge-Munsee Band of Mohican, Tribal Vice President ***Greg Miller***, and tribal council members ***Joe Miller*** and ***Scott Vele***, who is also the Executive Director of the Midwest Alliance of Sovereign Tribes (MAST). Topics discussed included IHS underfunding of Bemidji area tribes relative to other regions, concerns about how health reform will affect tribes, concerns about recruitment of health care providers and frustration with this year's tribal consultation process across HHS. RD sent concerns to IGA for follow up.

Oneida Tribe of Wisconsin, February 2010

RD Thomas and IHS Area Director ***Jenkins*** met with ***Kathy Hughes***, Vice Chair of the Oneida Tribe of Wisconsin, and senior staff of the Oneida Community Health Center. Topics discussed included Medicaid issues and the impact of the President's budget on tribes. RD followed up with CMS RO on Medicaid issues.

Saginaw Chippewa Indian Tribe (Michigan)

RD Thomas and IHS Area Acting Director ***Jenkins*** visited the Saginaw Chippewa Indian Tribe, toured the Nimkee tribal clinic and met with ***Michelle Stanley***, President of the Midwestern Alliance of Sovereign Tribes, ***Clinton Pelcher***, Interim Director and Chair of the Saginaw Chippewa Indian Tribe, and other tribal leaders. Topics discussed include health care reform, and the impact of reform on tribal members. Other health priorities discussed include maternal and child health (the cultural aspects of tribal birthing) and behavioral health. The tribe participates in the Access to Recovery Grant, which has been successful in allowing the tribe to incorporate culturally competent practices into treatment.

Little Traverse Bank of Ottawa Indians (Michigan), March 2010

RD Thomas and ***Jenny Jenkins*** visited the Little Traverse Bank of Ottawa Indians and met with ***Sharon Sierzputowski***, Health Director, ***Ken Harrington***, Tribal Chairman, ***Dexter McNamara***, Tribal Vice Chairman, ***Dr. Terry Samuels***, Medical Director, and ***Chris LePage***, Lead Mental Health Therapist. Topics discussed include the significant growth in active patients they have experienced in the tribal clinic, challenges with the Contract Health Service, and the closing out of the Access to Recovery Grant, which they participate in as part of the Intertribal Council of MI Tribes.

Grand Traverse Band of Ottawa and Chippewa Indians (Michigan), March 2010

RD Thomas and IHS Area Director ***Jenkins*** visited the Grand Traverse Band of Ottawa and Chippewa Indians and met with ***Dr. Kelly O'Sullivan***, Health Director, and ***Loi Chambers***, Business Manager. Topics discussed include implementation of electronic health records, the need for technical assistance and education on health care issues for tribal leadership. Jenny Jenkins will follow up to provide IHS technical assistance.

Little River Band of Ottawa Indians/Match-E-Be-Nash-She-Wish Band of Pottawatomi Indians (Michigan), March 2010

RD Thomas and IHS Area Director ***Jenkins*** visited the Little River tribal clinic, then Match-E-Be-Nash-She-Wish Band of Pottawatomi Indians, meeting with Gun Lake Tribe Health Director, ***Phyllis Davis***, and Tribal Chairman DK Sprague. Topics discussed include relationships with state and local governments, electronic medical records, the impact of state budget cuts on the demand for tribal health care, and concerns about state/county compliance with the Indian Child Welfare Act.

Mille Lacs Band of Ojibwe Indians (Minnesota), April 2010

RD Thomas traveled to Onamia, MN with IHS Area Director ***Jenkins*** to visit the Mille Lacs Band of Ojibwe Indians. They met with ***Don Eubanks***, Commissioner of Health and Human Services and other appointed officials of the Mille Lacs Band.

Minneapolis Urban Health Program, April 2010

RD Thomas and IHS Area Director ***Jenkins*** traveled to Minneapolis MN, met with ***Dr. Patrick Ross***, Medical Director and CEO of the Indian Health Board of Minneapolis and visited the Fond Du Lac urban pharmacy program.

Ho Chunk Chicago Membership Town hall Meeting, August 2010

RD Thomas participated in the Ho Chunk Chicago members' monthly town hall meeting with Ho Chunk District 5 Legislators, highlighting the Affordable Care Act (ACA). As follow-up, RD Thomas provided response to issues/concerns raised, including ACA insurance mandate and mobile clinic resources.

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REGION 6: Dallas

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HIGHLIGHTS OF REGION- SPECIFIC ACCOMPLISHMENTS

Region VI Tribal Quarterly Conference Call

The call was joined by twenty-four tribes who were able to ask questions of the regional policy experts and national HHS staff.

SUMMARY OF REGIONAL TRIBAL CONSULTATION SESSIONS

Atlanta Consultation Session, Atlanta, Georgia, March 30, 2010

RD Petty in the Region VI Tribal Consortium with attendance from the Alabama-Coushatta of Livingston, Texas, the Coushatta Tribe of Louisiana and the Chitimacha Tribe of Louisiana. HHS IGA representatives included ***Anne Filipic*** and ***Stacey***

Ecoffey; ANA Commissioner ***Lillian Sparks*** and representatives from the CDC and the director of the IHS Nashville Area Office.

The tribes expressed an interest in having the RD visit the Tribal sites to learn more about the tribes, their work and programs. The Tribes discussed the need for having a reliable and regular communication system with the RD's office. Tribal leaders would like to share best practices with other Tribes in the area. Tribes also expressed an interest in learning more about grants.

Since the consultation, the RD has visited each tribal office in person to discuss HHS issues, to learn more about the tribes and to meet tribal leaders and staff. There has also been a conference call with the tribes to discuss the Affordable Care Act and other national updates pertaining to the tribes. During this first quarterly call, the tribes were able to ask policy questions of Region VI experts and to learn more about grants available to them. Email communication with the tribes has also been established to share important HHS tribal updates and information.

2010 Region 6 Tribal Consultation Session, Albuquerque, New Mexico, April 22, 2010

RD Petty and ***RD Baker*** were present with a total of 170 participants. Presentations included: ***Michael Strautmanis,*** Chief of Staff to the Assistant to the President for Intergovernmental Relations and Public Engagement shared information from the White House with the participants. ***Dr. Yvette Roubideaux***, Director, IHS described the Secretary's plan to establish a Tribal Advisory Committee and a Tribal-Federal Work Group to review all of the comments of the tribal consultations and to make recommendations for improving the consultation process. She also reviewed the FY 2010 budget, which provides the largest increase for Indian health in 20 years. Dr. Roubideaux also highlighted portions of the Affordable Care Act that will impact tribal nations. ***Cindy Padilla***, Principal Deputy Assistant Secretary for Aging also spoke and spotlighted her interest in working with Tribes to serve elders and their long-term care needs. ***Lillian Sparks***, Commissioner of the Administration for Native American, encouraged feedback from the tribes for human service programs as well as health programs. ***Stacey Ecoffey***, Principal Advisor for Tribal Affairs, IGA and ***Paul Dioguardi***, Director, IGA also participated in the meeting.

Tribal leaders stressed that the consultations are government-to-government. They expressed frustration that the consultations do not result in discernible changes from year to year. Consultations should educate, empower and engage. They stressed that tribes differ and that HHS leadership should visit each Tribe to understand its unique issues. The tribal leaders stressed the need for data, including the need to set benchmarks for reducing health disparities. They emphasized the need for community-based and intermediate care facilities to address long-term care needs. Also emphasized was the need for more resources, especially for substance abuse issues and suicide prevention. The leaders stressed the need to address challenges for urban American Indians to access health services. Tribal leaders provided input on improving the consultation process to include the suggestion of a template so that there is uniformity across the nation and consultation performance measures.

SUMMARY OF TRIBAL DELEGATION MEETINGS

Choctaw Leaders and Senior Day Celebration, Durant, Oklahoma, May 25, 2010

RD Petty met with ***Choctaw Chief Greg Pyle***, ***Mickey Percy***, Choctaw Director of Health; ***Gary Batton***, Assistant Chief; ***Shannon McDaniel***, Director of Social Services; and ***Oneida Winship***, Director of Elderly Programs.

Cherokee Nation 10th Annual Government Relations Retreat and Cherokee National Holiday, **Tulsa and Tahlequah, Oklahoma, September 3-4, 2010**

RD Petty attended ***Principal Chief Chad Smith's*** State of the Nation address and spoke with the Chief about his meeting with Secretary Sebelius. RD Petty discussed the design of the Region VI child support enforcement conference with Cherokee Director and ***Roy Nix***, Director of Regulatory Operations with the Administration for Children and Families, Washington, D.C. RD Petty spoke with ***Sam McCracken***, a Cherokee entrepreneur who organized a Native American program for Nike Sports Company.

REGIONAL VISITS TO TRIBES

Seminole Tribe, Wewoka, Oklahoma, May 26, 2010

RD Petty met with Principal ***Chief Leonard M. Harjo*** and Assistant ***Ella Colman*** to discuss the Affordable Health Act, the Let's Move initiative and other health and human services topics of mutual interest.

Kewa, Chochiti and Sandia Pueblos, Albuquerque, New Mexico, August 19, 2010

RD Petty visited with leaders from the Kewa, Cochiti and Sandia Pueblos in as a follow-up to the regional consultation meetings and to discuss the Affordable Care Act, the Let's Move initiative, environmental health concerns, and other health and human services issues of mutual interest. RD Petty met with ***Ron Solimon***, President and CEO, Indian Pueblo Cultural Center, Albuquerque, New Mexico; ***Ken Lucero***, Director of the Robert Wood Johnson Center for Native American Health Policy at the Indian Pueblo Cultural Center; ***Beth Sanchez***, Director of Health and Social Services, Pueblo of Sandia. The RD met with the following representatives of the Cochiti Pueblo: ***Governor Vernon Garcia; Calvin Suina***, Health and Human Services Director; ***Jacob Pecos***, Director of Natural Resources and Conservation; and ***Lee Suina***, Manager of Environmental Services. Additionally, the RD met with the following individuals representing the Kewa Pueblo: ***Governor Tony Tortalita*** and Tribal Program Administrator ***Ray Tafoya***.

Pueblos of San Felipe and Pojoaque, New Mexico, August 20, 2010

RD Petty reached out to ***Charlotte Little***, Tribal Administrator for the Pueblo of San Felipe and ***Jimmy Real***, Lt. Governor for the Pueblo of Pojoaque to discuss the Affordable Health Act, the Let's Move initiative, community health worker information and other health and human services topics of mutual interest. Additional funding for tribes was also discussed as well as technical assistance for grants.

Pueblo of Tesuque of New Mexico, Santa Fe, New Mexico, August, 20, 2010

RD Petty participated in a meeting of tribal health care leaders and governors at the Santa Fe, New Mexico Indian Health Services unit. The meeting focused on the Affordable Care Act and Native American health care issues, community health worker opportunities, the Let's Move initiative, and other health and human services topics of mutual interest. In attendance: ***Ken Lucero***, Director of the Robert Wood Johnson

Center for Native American Health Policy at the Indian Pueblo Cultural Center; ***Governor Frederick Vigil*** of the Pueblo of Tesuque.

Zuni Pueblo of New Mexico, August 23, 2010

RD Petty discussed the Affordable Care Act; the reauthorization of the Indian Health Care Improvement Act; the Let's Move initiative, childhood obesity and diabetes; additional funding for tribes, technical assistance for grants and other health and human services issues of mutual interest. RD Petty met with ***Governor Norman Cooeyate***, ***Lt. Governor Dancy Simplicio***, six council members, nine tribal program representatives, and two administrative officials with the Pueblo of Zuni.

Laguna Pueblo of New Mexico, August 23, 2010

RD Petty discussed the Affordable Care Act; the reauthorization of the Indian Health Care Improvement Act; the Let's Move initiative, childhood obesity and diabetes; and other health and human services issues of mutual interest. RD Petty met with ***Paul Pino***, Chair of the Health Priority Committee; ***Ramona Dillard***, Sports and Wellness Director; and other tribal program directors whose work focuses on behavioral health and diabetes.

ChitimachaTribe, Charenton, Louisiana, November 12, 2010

RD Petty met with ***Tricia Mora***, Division Administrator for Social Services, along with the Executive Officer/Tribal Manager, Clinic Director, and the Director of Health and Human Services. RD spoke about the Affordable Care Act, Healthcare.gov, the Secretary's Tribal Advisory Council, updates on tribal consultation, National Prevention Strategy and regional tribal outreach activities. The tribe was interested in learning more about additional funding as well as technical assistance for grants.

Coushatta Tribe of Louisiana, Elton, Louisiana, November 12, 2010

RD Petty met with ***Paula Manual***, Clinic Director; ***Milton Hebert***, Director for Social Services; the Director of Nursing, and the individual in charge of converting the tribal clinic's medical records to electronic files. RD Petty spoke about the Affordable Care Act, Healthcare.gov, the Secretary's Tribal Advisory Council, updates on tribal consultation, National Prevention Strategy and regional tribal outreach activities. The RD and tribal officials also discussed extensively a Tribal Just Move It program started by the Zuni Tribe a few years ago that is very similar to the Let's Move Initiative. Additional funding for tribes was also discussed as well as technical assistance for grants.

Jemez Pueblo Health Clinic, Jemez Pueblo of New Mexico, November 15, 2010

EO Lothrop and ***ROS Chavez*** joined ***Luis Rosero***, HHS Deputy Assistant Secretary of Office of Public Affairs toured the clinic and pharmacy while discussing physician recruitment, services and funding. The Pueblo has a Communities Putting Prevention to Work grant, which has propelled them to create a community garden that provides snacks for the school children. They have integrated fitness and exercise in the school schedule and have been emphasizing nutrition and wellness. The Pueblo has a fitness center that has been creative in its programming and has increased participation. They have also sponsored organized bike rides and runs to encourage a spirit of competition and culture of fitness. In addition to touring the location, the HHS officials had the opportunity to meet with all of the directors of health services.

TRIBAL SUMMITS

2nd Annual Oklahoma Area Tribal Epidemiology Conference, Norman, Oklahoma, September 14-15, 2010

This meeting focused on cardiovascular disease, physical activity, behavioral health, maternal and child health, injury prevention and translating research into practice. ***RD Petty*** met with ***Terri White***, Commissioner , Oklahoma Department of Mental Health and Substance Abuse; ***Dr. Adeola Jaiyeola***, Epidemiology Manager; ***Susan Harman***, Epidemiologist with the Oklahoma City Inter-Tribal Health Board; ***Michelle Gauthier***, Research Associate with the Program in American Indian Community Health with the University of Kansas Medical Center.

Oklahoma Indian Health Service Tribal Consultation, Oklahoma City, Oklahoma, November 5, 2010

RD Petty presented on the Secretary's Tribal Advisory Council, updates on tribal consultation, the Affordable Care Act, National Prevention Strategy and regional tribal outreach activities. Twenty-five Oklahoma and Kansas tribes and one Texas tribe were present as well as ***Dr. George Howell***, member of the HHS Tribal-Federal Work Group focusing on Tribal Consultation, ***Charles Grim*** and ***Dr. Everett Rhoades***, both former Indian Health Service directors .

Tribal Suicide Prevention Summit, Oklahoma City, OK, December, 13, 2010

RD Petty participated with 20 Tribes from the Oklahoma area. The meeting was co-hosted by the Cherokee Nation and SAMHSA and included ***Dr. Kevin Meeks***, Director Indian Health Service.

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HIGHLIGHTS OF REGION-SPECIFIC ACCOMPLISHMENTS

RD Baker facilitated Tribal, State, CMS and IHS group session, July 28, 2010

RD Baker discussed two major interests (1) the possibility of Kansas tribes using Tribal funds in contributions to Medicare Part A, B or D payments for Tribal elders. CMS is continuing to provide input for this matter. (2) The second topic addressed epidemiologic cancer data collection and sharing of which there is currently no mutual system. Action from this discussion includes ***CAPT Tahsuda*** will communicate with Oklahoma IHS epidemiologist and ***Dr. Lai*** to keep this topic active, the LCDR Branch will continue providing information about grant opportunities, and ***Chairman Ortiz*** will develop an MOU template for Kansas tribes that will allow data collection.
Attendees of this session included: ***Chairman Steve Ortiz*** and ***Carrie O'Toole***, Tribal Council Member, ***Jerry Briscoe***, Potawatomi Health Clinic Director, all of the Prairie Band Potawatomi Nation, ***Russell Bradley***, Tribal Council Member, Kickapoo Tribe, ***Dee Ann DeRoin***, Health Consultant and Chair of the *Four Tribal Women's Wellness Coalition*, ***Roderick Bremby***, Secretary, Kansas Department of Health and Environment, ***Sue Lai***, Epidemiologist, University of Kansas Medical Center**,** ***CAPT Max Tahsuda,*** Director, Tribal Self Determination, Oklahoma Indian Health Service, ***Nancy***

Rios, External Outreach Coordinator and Tribal Liaison, Centers for Medicare and Medicaid Services, ***LCDR Tracy Branch***, Program Coordinator, Office of Minority Health/Office of Public Health and Science, and ***Adele Hughey***, Intergovernmental Affairs Specialist.

RD Baker aided Tribal Resource Day, Kansas City, Kansas September 8/9, 2010

RD Baker provided an overview of the Affordable Care Act, she demonstrated healthcare web links to include (1) healthcare.gov, (2) the Indian Health Service website and (3) the IHS Director's weblog. Audience included seven Region Tribes, more than 60 participants and tremendous HHS support from 8 HHS divisions and 4 other federal entities listed below. Primary outcomes included (1) expanded opportunities for HHS Operating Divisions to speak with Tribal Leaders and (2) grant opportunity announcements. It was suggested that a similar meeting planned again.
Attendees included: HHS divisions Centers for Medicare and Medicaid Services, Administration for Children and Families, Office of the Assistant Secretary for Health, Health Resources and Services Administration, Indian Health Services, Office of the Assistant Secretary for Preparedness and Response, Agency for Toxic Substances and Drug Registry, and Administration on Aging. Other federal participants included Federal Emergency Management Administration, Environmental Protection Agency, Veterans Administration and Social Security Administration. Each provided brief updates on their programs and provided resource materials. Nebraska Community College and the University of Kansas Medical Center also made presentations.

SUMMARY OF REGIONAL CONSULTATION SESSIONS

HHS Region 6 & 7 Tribal Consultation Session, Pueblo Indian Cultural Center, Albuquerque, New Mexico, April 22, 2010

Attendance numbered 170 total with 5% of participants from Region 7, 51% from Region 6. Federal leaders included: ***Michael Strautmanis***, Chief of Staff to the Assistant to the President for Intergovernmental Relations and Public Engagement; ***Dr. Yvette Roubideaux***, Director, Indian Health Service; ***Cindy Padilla***, Principal Deputy Assistant Secretary for Aging; ***Lillian Sparks***, Commissioner of the Administration for Native Americans, Administration for Children and Families; ***Paul Dioguardi***, Director, Intergovernmental Affairs, and ***Stacey Ecoffey***, Principal Adviser for Tribal Affairs, Intergovernmental Affairs. ***Charlene Red Thunder***, Director for the Aberdeen Area Office and ***CAPT Kevin Meeks***, Director of the Oklahoma City Area. Additional Federal staff in attendance was ***Jeff Hinson***, Regional Administrator, Centers for Medicare and Medicaid Services Region 7 & 8, ***Richie Grinnell***, Acting Indian Health Services Director Albuquerque, and ***Dr. Leonard Thomas***, Medical Director, Indian Health Services Albuquerque. ***Region 6 HHS Staff*** who participated in the Consultation were, Carl Rich, Jane Martin, Nanette Bishop, Dana Huckabee with Administration for Children and Families, Stacey Whuman, Paula Hammond, Bill Brooks, Dorsey Sadongei with Centers for Medicare and Medicaid Services, Larry McClendon with Administration on Aging, Minnie Green with Office on Civil Rights and Jeff Jordan with Health Resources and Services Administration.
important ***Chairman Ortiz*** points included (1) Oklahoma Area IHS announced distribution of funds clinics with tele-health capabilities, (2) the American Recovery and Reinvestment Act funds are available to tribes to improve buildings, (3) Adding more funds to address prevention would be a good investment and likely reduce acute care in subsequent years, (4) Need for an increase in Catastrophic Health Emergency Fund (CHEF) funds, (5) Estimates 40% of seniors in Prairie Band Potawatomi Tribe are

dropping Part B of Medicare. Chairman Ortiz is trying to pay the monthly fee for them. Important points from ***Marianna Fox (Ponca)*** included (1) the inability to apply directly for Title X funds from federal government, they must apply through state of Nebraska, (2) Continued issues with grant awards process that include low tribal population not sufficient for grant requirements, lack of tribal specificity for tribe, inaccurate tribal formularies, and the lack of evidence-based studies/programs in Indian Country, especially highlighted this problem for Substance Abuse and Mental Health Services Administration services. (3) Quality epidemiology is critical and Native Americans are not being counted accurately, I.e. Chairman Ortiz states, "Born Indian, but die white" on death certificates.

Affordable Care Act impact on tribes

RD Baker continues to provide Weekly Affordable Care Act Bulletin distributed by email to all tribal leaders, the White House call for Tribal Leaders on the Affordable Care Act is distributed to all tribal leaders.

Tribal Data Collection and need for quality epidemiology research

The need for quality epidemiology is critical particularly for smaller populated tribes and there is a need to address how the grant process is conducted. At the request of Chairman Steve Ortiz of the Prairie Band Potawatomi Nation, a meeting was scheduled with representatives from, the State of Kansas, University of Kansas Medical Center epidemiologist, and Oklahoma City Area Indian Health Service staff to discuss data collection of Native American demographics. Identify data collection systems currently available in the Region for Indian County and identify new opportunities under Affordable Care Act and Indian Health Care Improvement Act. Contact Substance Abuse and Mental Health Services Administration to determine what steps should be taken to improve the success rate for Tribal applications

Grant writing to eliminate health disparities in Region 7

The offering of free grant writing workshops should be continued. The dates for the free grant writing workshops were October 12-13, 2010. Continue to explore opportunities to provide technical assistance during the grant writing process and determine the number of grants submitted.

To identify the training needs of the tribes and develop strategies to deliver those training opportunities as needed

Continued identification of tribes who would be interested in training and/or technical assistance with their clinics. Continue to develop multiple strategies to deliver the training. Identify who would be available to conduct training and technical assistance and schedule dates with tribal entities

Improve Tribal/State partnerships for health

Identify state contacts and liaisons for selected state departments and strive to develop working and open communications. To Invite State contact to participate on Quarterly Tribal Call as needed.

REGIONAL VISITS TO TRIBES

Kansas State Centers for Medicare and Medicaid Services' Tribal Consultation at the Prairie Band Potawatomi Health & Wellness Center on the reservation in Mayetta, Kansas, February 17, 2010

The goal of the meeting was to continue building better relationships between the tribal and state leaders. There was expressed interest in electronic health records. The State of Kansas committed to assist with enrollment procedures. There was favorable feedback for a regional "resource day" after Tribal Consultation.

Nebraska State/Tribal Consultation Meeting,The Fred LeRoy Health & Wellness Center, Omaha, Nebraska, February 18, 2010

Topics of discussion included (1) Medicaid enrollment, (2) American Recovery and Reinvestment Act #6 memo, (3) Children Health Insurance Program Reauthorization #11 memo, and the (4) Medicare Learning Network.
Attendance included: ***Nancy Rios*** (Centers for Medicare and Medicaid Services), ***Jeff Hinson*** (Centers for Medicare and Medicaid Services), ***Darcy Jacopchek***, (Centers for Medicare and Medicaid Services). Tribal Leader attendance included Chairman ***Larry Wright***, Ponca Tribe, Chairman ***Blackhawk,*** Winnebago Tribe, and representatives from the Santee Sioux, and Omaha Tribes. ***Charlene Red Thunder*** Area Director of the Aberdeen Area Indian Health Service ***Viviane Chaumont***, Director of the Division of Medicaid & Long-Term Care of the Nebraska Department of Health and Human Services, and ***Jill Schreck*** with the Nebraska Division of Children and Family Services.

HHS RD and CMS met with Health Center in Kansas, Missouri, March 15, 2010

RD Baker met with ***Cheyanne LeRoux Ingram***, Executive Director of the Heart of America Indian Center in Kansas City, MO and Centers for Medicare and Medicaid Services Regional External Affairs staff ***Nancy Rios***. The Regional Director toured the facility and discussed outreach to the community regarding the census and linking Centers for Medicare and Medicaid Services materials on their website. Ms. Rios and the RD also discussed further partnering with Tribes.

Kansas Tribal Medicaid Meeting, June 9, 2010

RD Baker delivered welcoming remarks and participated with ***Nancy Rios***, Regional Native American Contact, Centers for Medicare and Medicaid Services**,** at the Kansas Tribal Medicaid Meeting. Items on the agenda were tribal participation on state advisory committees, technical assistance and training needs, and provisions of Affordable Care Act and Indian Health Care Improvement Act.

Nebraska Tribal Medicaid Meeting, June 10, 2010

RD Baker gave welcoming remarks and participated with ***Nancy Rios***, Regional Native American Contact, Centers for Medicare and Medicaid Services, at the Nebraska Tribal Medicaid Meeting. Agenda items included SPA's, participation on state advisory committees, Affordable Care Act and Indian Health Care Improvement Act.

Kansas Health Meeting, July 28, 2010

RD Baker facilitated discussion on (1) Kansas Tribal methodology for Tribal funds to pay for Medicare Part A, B or D payments for Tribal elders. CMS will meet with Tribal Leaders to discuss potential payments of Medicare Part D. (2) Cancer data collection for Kansas Tribes.

Attendance included: Chairman ***Steve Ortiz*** and ***Carrie O'Toole***, Tribal Council Member, Prairie Band Potawatomi Nation, ***Jerry Briscoe***, Health Director, Prairie Band Potawatomi Health Clinic, ***Russell Bradley***, Tribal Council Member, Kickapoo Tribe, ***Dee Ann DeRoin***, Health Consultant and Chair of the *Four Tribal Women's Wellness Coalition*, ***Roderick Bremby***, Secretary, Kansas Department of Health and Environment, ***Sue Lai,*** Epidemiologist, University of Kansas Medical Center**,** ***CAPT Max Tahsuda***, Director, Tribal Self Determination, Oklahoma Indian Health Service, ***Nancy Rios***, External Outreach Coordinator and Tribal Liaison, Centers for Medicare and Medicaid Services, ***LCDR Tracy Branch***, Program Coordinator, Office of Minority Health/Office of Public Health and Science, and ***Adele Hughey***, Intergovernmental Affairs Specialist. ***CAPT Tahsuda*** will engage the Oklahoma Indian Health Service Epidemiologist and ***Dr. Lai*** to find a way that they can share data. ***LCDR Branch*** committed to providing Tribes information about Grant opportunities. ***Chairman Ortiz*** will make a Memorandum of Understanding template for Kansas Tribes that will allow data collection.

Prairie Band Potawatomi Nation conference center during Centers for Medicare and Medicaid Services Meeting, Mayetta, Kansas, Aug 18, 2010

RD Baker demonstrated healthcare.gov portal to 70 participants that included Tribal health care leaders and state healthcare officials. An outreach and training session was conducted.

February 17, 2010. ***RD Baker*** met with Tribal leaders for introductions and confirmation of building better relationships between the tribal and state leaders. The following were in attendance: ***Alan Kelley***, Vice Chairman and ***Nina Merchant*** Tribal Council Member (Iowa Tribe of Kansas & Nebraska, ***Arlan Whitebird***, Tribal Chairman (Kickapoo Nation), ***Steve Ortiz***, Chairman (Prairie Band Potawatomi Nation).

Nebraska State/Tribal Consultation Meeting, the Fred LeRoy Health & Wellness Center, Omaha, Nebraska, February 18, 2010.

RD Baker met with Tribal Leaders Chairman ***Larry Wright***, Ponca Tribe, Chairman ***John Blackhawk***, Winnebago Tribe, and **representatives** from the Santee Sioux, and Omaha Tribes.

July 12, **2010.** RD Baker met with Tribal Leaders to brief Tribes on the Affordable Care Act, the healthcare.gov portal and discussed Tribal Resource Day. RD Baker also toured the new clinic and assisted living facility. Attendance included: Vice-Chairman ***John Papakee***, ***Rudi Papakee***, Health Director, of the Sac and Fox Nation of the Mississippi in Iowa (Meskwaki Tribe) and four council members.

TRIBAL SUMMITS

Indian Health Service and Aberdeen Areas Tribal Chair Health Board Meeting and Listening Session, Rapid City, South Dakota, May 26, 2010

RD Baker met with ***Charlene Red Thunder*** to discuss the option of developing a customized consultation policy for Aberdeen Area IHS, to be similar to the Bemidji Area IHS policy.

Tribal Resource Day, Kansas City, Kansas, September 8-9, 2010

RD Baker met with 7/9 Regional tribes to discuss the Affordable Care Act and gave a website demonstration of the (1) healthcare.gov portal, (2) Indian Health Service website

and (3) Director's weblog. IHS Director ***Dr. Roubideaux*** provided video welcome remarks and an update on implementation of Indian Health Service improvements. HHS operations stated below each provided brief updates provided resource materials. Nebraska Community College and the University of Kansas Medical Center also made presentations.

Over 60 participants were in session and this included: Centers for Medicare and Medicaid Services, Administration for Children and Families, Office of the Assistant Secretary for Health, Health Resources and Services Administration, Indian Health Service, Office of the Assistant Secretary for Preparedness and Response, Agency for Toxic Substances and Disease Registry, and Administration on Aging. Other federal participants included Federal Emergency Management Administration, Environmental Protection Agency, Veterans Administration and Social Security Administration.

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HIGHLIGHTS OF REGION-SPECIFIC ACCOMPLISHMENTS

- Created Suicide and Child Abuse Prevention Committee through the initiation of the Administration for Children and Families Regional Administrator, ***Tom Sullivan***.
- Formed HHS internal Tribal Taskforce Committee to discuss tribal issues in the region in the various operating divisions. Use the taskforce to discuss action plans and set up planning meetings for Tribal Consultation.
- Set up monthly calls/emails with Tribal Leader's to continue communication.
- Send out monthly emails on HHS grant opportunities and announcements.

SUMMARY OF REGIONAL CONSULTATION SESSIONS

Regional Tribal Consultation, Denver, Colorado, May 5, 2010

Total attendance was 108 and included: Representatives from ***19 federally recognized tribes***, ***11 Tribal Chairmen***, ***RD Marguerite Salazar***, ***Dr. Donald Warne***, Director of

Aberdeen Area Tribal Chairmen's Health Board, ***Curtis Cesspooch***, Chairman, Ute Indian Tribe of the Uintah and Ouray Reservation, ***Jonathan Windy Boy,*** Vice Chairman, of the Chippewa Cree Indians of the Rocky Boy Reservation, ***Pamela Hyde***, Administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA) represented the Office of the Secretary Kathleen Sebelius, ***Teresa Nino***, Director of External Affairs, Centers for Medicare and Medicaid Services (CMS).

Top 10 Issues of Concern

1. The funding level for the Indian Health Service. Currently, the IHS is not properly funded. IHS needs to provide adequate health care on Region VIII reservations. Funding from U.S. government is pitting tribal organizations and Tribes against each other (e.g. federally recognized tribes, state tribes and urban tribal organizations)
2. With the upcoming changes to CHIP and CMS' effort to work more closely with tribes on Medicare/Medicaid services - more information is needed for tribal members.
3. There is high unemployment on the reservations and no opportunities for youth to get work experience.
4. A strong need for health education of tribal members to help reduce the high incidence of diabetes, heart disease, alcoholism, and other health related problems.
5. A common concern expressed by tribal leaders was the need to access HHS grants. Accessing these grants involves both learning of the grants as well as being able to successfully write the necessary grant applications.
6. Who do we communicate with at the Regional and National level when we have an issue or concern?
7. Need for assistance in behavioral health issues in the region and states.
8. There is a need for separate funding for buildings to house health clinics, administrative buildings and ambulance facilities.
9. More funding for contract care, many tribal members going without health care.
10. Privacy issues of family members and their medical records, Health Information Privacy Accountability Act (HIPAA)

TRIBAL DELEGATION MEETINGS

June 9, 2010. ***RD Salazar*** met with Utah Indian Tribal Health Advisory Board

June 10, 2010. *RD Salazar* met with Utah Indian Tribal Human Services Advisory Board

June 10, 2010. ***RD Salazar*** met with Dorothy Dupree, IHS Tucson/Phoenix Area Director

June 10, 2010. *RD Salazar* met with Utah Tribal Leader's Council

August 18, 2010. *RD Salazar* met with ***Martin Skye*** and United Sioux Tribes Development Corporation, and other Tribal Officials. RD Salazar learned about efforts in developing the United Sioux Tribes Health Information Database

REGIONAL VISITS TO TRIBES

July 14, 2010. *RD Salazar* met with ***Eddie Wadda***, Tribal Liaison for Eastern Shoshone of Wind River Reservation.

July 15, 2010. ***RD Salazar*** met with ***Garrett Collins***, Tribal Liaison Arapaho Tribe of Wind River Reservation

August 3, 2010. ***RD Salazar*** met with ***Marjorie Bear Don't Walk,*** Urban Indian Clinic/Indian Health Board of Billings.

August 10-11, 2010. ***RD Salazar*** attended the Pathways to Respecting American Indian Civil Rights conference in Albuquerque, NM. RD Salazar represented the Department of Health and Human Services at the Federal Round Table.

August 17, 2010. ***RD Salazar*** addressed Area Directors at IHS National Meeting in Rapid City.

August 17, 2010. ***RD Salazar*** met with ***Ron His Horse is Thunder,*** interim director for the Aberdeen Area Tribal Chairmen's Health Board.

TRIBAL SUMMITS

Utah Governor's Tribal Summit, August 31- Sept 2, 2010

RD Salazar attended the Utah Summit where she met with ***Governor Gary Herbert, Lt. Governor Greg Bell***, Utah Health and Human Services and Utah Tribal Leaders. Tribal leaders addressed the Governor and his staff on issues and concerns they have within the state.

United States Department of Health & Human Services
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SUMMARY OF REGIONAL CONSULTATION SESSIONS

Valley Center, California, April 27, 2010

Representatives from the federally recognized tribes, tribal councils, and tribal health boards participated from the Region IX area (CA, AZ, NV, and Navajo Nation). Chairman ***Robert Smith***, Pala Band of Mission Indians, provided the *Tribal Opening* and *Tribal Closing.* ***Bo Mazzetti***, Chairman, Rincon Band of Luiseno Mission Indians, gave the *Tribal Welcome.*

Phoenix, Arizona, April 29, 2010

Representatives from the federally recognized tribes, tribal councils, and tribal health boards participated from the Region IX area (CA, AZ, NV, and Navajo Nation). ***Chester***

Antone, Council Member of the Tohono O'odham Nation Legislative Council, gave the *Tribal Opening* and *Tribal Closing.* Chairman ***Waldo Walker***, Washoe Tribe, gave the *Tribal Welcome.*

Attendance included: ***Anne Filipic***, Deputy Director of the HHS Office of Intergovernmental Affairs (IGA), represented the Office of the Secretary Kathleen Sebelius, ***Stacey Ecoffey***, Intergovernmental Affairs staff, tribal representatives and representatives from Hawaii. Other partners included: Indian Health Service, SAMSHA, Administration for Children and Families, the Centers for Medicare and Medicaid Services, the Health Resources and Services Administration, the Administration on Aging, the Office of the Assistant Secretary for Health, and the Office of Civil Rights.

The top five issues for this region include:

1. Elimination of Medicaid Optional Services due to shrinking budget.
2. Priority issues working with TANF are: "arms length process", no clear means of consultation and problem resolution.
3. ACF does not have a comprehensive tribal consultation policy.
4. Need for more substance abuse and mental health services.
5. Need to have a reporting mechanism to communicate updates back to the Tribes. There is also a need for documentation of actions taken to address such items as the President's memo on Tribal Consultation Policy, Health Care Reform and allocation of stimulus money.

Follow up after the Regional Consultation (April 2010)

RD Schultz has developed a workgroup of Tribal health and social services directors in California to discuss pertinent HHS related issues on a more regular basis.

RD Schultz has also offered the opportunity to form a Tribal Chairman's workgroup as well as health and social services workgroups in each of our other Region IX states.

RD Schultz has followed up on the following 2010 consultations:

1. The need for additional substance abuse and mental health services. This issue was forwarded to Washington, DC with specific request for SAMHSA to increased staff in region. Placement of additional staff in 5 out of the 10 regional offices will be initiated in 2011. Placements in the other 5 regional offices will follow in a timely manner.
2. The Tribes request increased communication with HHS regional office. RD Schultz has established a tribal stakeholder's email list where weekly updates regarding health care reform and other HHS programs are sent to Tribes. This information has generated additional questions as well as funding opportunities for Tribal organizations.

REGIONAL VISITS TO TRIBES

Gila River Indian Community and Title V Urban Indian Health Clinic Visit, Phoenix, Arizona, April 28, 2010

RD Schultz accompanied ***Lillian Sparks***, Commissioner, Administration of Native Americans visited Gila River health clinic, the Urban Indian Health Program in Phoenix and Phoenix Indian Medical Center. RD Schultz and Commissioner Sparks participated in discussion regarding the Affordable Care Act. Attendance included: ***Anne Filipic***, Deputy Director of the HHS Office of Intergovernmental Affairs and ***Stacey Ecoffey***, IGA Principal Advisor for Tribal Affairs.

Washoe Tribe of Nevada, San Francisco, California, May 14, 2010

RD Schultz met with Chairman ***Waldo Walker*** and ***Jorge Lopez*** of the Washoe Tribe of Nevada to discuss follow-up from the Arizona tribal consultation session that was held in Phoenix. Additional meetings with Tribes were held by conference call and are detailed below in the Regional Visits to Tribes section of this report.

Pala Band of Mission Indians, May 14, 2010

RD Schultz met with ***Robert Smith***, Tribal Chairman, Pala Band of Mission Indians, to discuss follow-up from the California tribal consultation session that was held in San Diego, California.

Indian Health Board of Nevada, May 14, 2010

RD Schultz met with ***Larry Curley***, Executive Director of the Indian Health Board of Nevada (IHBN) prior to giving a presentation at the June 3, 2010 board meeting in Reno, Nevada. The IHBN works with Nevada's tribal leaders, tribal health care providers, local state and national leaders in sharing and exchanging information with the underlying goal of improving access to quality health care.

Nevada Urban Indians, Carson City, Nevada, **June 2, 2010**

RD Schultz met with ***Daphne Emm***, Executive Director of the Nevada Urban Indians Inc. to discuss opportunities for collaboration. Nevada Urban Indians is a nonprofit, outreach and referral, community-based agency funded by private and public grants.

Inter-Tribal Council of Arizona, Phoenix, Arizona, June 21, 2010

RD Schultz met with ***John Lewis***, Executive Director of the Inter-Tribal Council of Arizona (ITCA), to discuss the Affordable Care Act and opportunities for collaboration. The members of ITCA are the highest elected tribal officials: tribal chairpersons, presidents and governors. Those attending the roundtable session included tribal leaders from 22 Tribes in Arizona.

California Tribal Health Directors, June 17, 2010

RD Schultz met with the California Tribal Chairman, Tribal council chairs and Tribal health and social services directors, to discuss the Affordable Care Act and the impact on tribes. In addition, several Medicaid issues and follow-up from the April Consultation were discussed.

Consolidated Tribal Health Project, June 25 and July 14, 2010

RD Schultz met with ***Frederick Rundlet***, Executive Director, Consolidated Tribal Health Project, Inc., and ***Molin Malicay***, CEO of Sonoma County Indian Health, to discuss California tribal issues and consultation policies. Both are considered health and social services leaders in the state of California.

August 17, 2010. Inter-Tribal Council of Arizona Roundtable, Phoenix, Arizona

RD Schultz conducted an all-day training and interactive discussion of the Affordable Care Act for the Inter-Tribal Council of Arizona (ITCA). The members of ITCA are the highest elected tribal officials: tribal chairpersons, presidents and governors from 22 of the following tribes: Ak-Chin Indian Community, Cocopah Tribe, Colorado River Indian Tribe, Fort McDowell Yavapai Nation, Fort Mojave Tribe, Gila River Indian Community, Havasupai Tribe, Hopi Tribe, Hualapai Tribe, Kaibab-Paiute Tribe, Pascua Yaqui Tribe, Pueblo of Zuni, Quechan Tribe, Salt River Pima-Maricopa Indian Community, San Carolos Apache Tribe, San Juan Southern Paiute, Tohono O'odham Nation, Tonto

Apache Tribe, White Mountain Apache Tribe, Yavapai-Apache Nation and Yavapai-Prescott Indian Tribe.

Indian Health Board of Nevada Quarterly meeting, September 2, 2010

RD Schultz was represented by ***Libby Vianu***, Regional Representative for ATSDR and Chair of Region IX Federal Regional Council (FRC) Tribal Affairs Subcommittee. She shared updates on HHS Tribal activities in Nevada, extended an invitation and begins planning discussions regarding RD Schultz's overview and interactive discussion on the Affordable Care Act, and began planning for the 3rd Annual State and Federal Inter-Agency Tribal Conference for Nevada. Ms. Vianu was acting on behalf of RD Schultz.

Inter-Tribal Council of Nevada, October 27-28, 2010

RD Schultz was represented by ***Libby Vianu***, Regional Representative for ATSDR and Chair of Region IX Federal Regional Council (FRC) Tribal Affairs Subcommittee and presented on HHS tribal activities in Nevada.

California Tribal Health Directors, November 30, 2010

RD Schultz coordinated a meeting between the (1) ***Toby Douglas***, California State Medicaid Director, (2) Department of Health Care Services (DHS) senior staff and (3) California tribal health and social service directors to address concerns with state Medicaid issues. RD Schultz focused on reimbursement for medical services to tribal country, frustration with the nation-to-nation consultation process and the Tribes interest to participate in a demonstration project. Tribal organizations represented included: Greenville Health, Redding Rancheria Health, Karuk Tribal Health, Feather River Tribal Health, Consolidated Tribal Health, Round Valley Tribal Health, Shingle Springs Tribal Health, Santa Ynez Tribal Health, Riverside Indian Health, Indian Health Council, Southern Indian Health Council, Toulumne Health, Sacramento Urban Health, Toiyabe Indian Health, Central Valley Tribal Health and Sonoma County Indian Health.

Indian Health Services, Phoenix, Arizona, December 9, 2010

RD Schultz and ***Eric Alborg***, Regional Outreach Specialist, met with IHS Phoenix Acting Director ***Dorothy Dupree*** and staff, including ***Keith Longie*** due to Phoenix Acting Director Dorothy Dupree being ill. Several members of the IHS were also members of nearby Tribes, including the Ak Chin Indian Community of Papago Indians, the Gila River Pima-Maricopa Indian Community of the Gila River Indian Reservation and the Navajo Tribe.

Gila River Indian Community, Phoenix, Arizona, December 10, 2010

RD Schultz and ***Eric Alborg***, Regional Outreach Specialist, met with leadership from the Gila River Health Care which is a 638 program and serves 2 Tribes. It also serves as their critical access hospital. RD Schultz toured the facility, discussed the implementation of health care reform and received a comprehensive briefing of programmatic functions within the hospital. Plans for collaboration included working with ***Aphreikah Duhaney*** (CEO), ***Dr. Noel Habib*** (CMO), ***Alan Urlich*** (CFO-interim), ***Joseph Remitera*** (Director - Primary Care Services), ***Ginger Fligger*** (Director - Managed Care), ***Esther Habib***, (Public Relations Assistant).

Indian Health Service, Tucson, Arizona, December 13, 2010

RD Schultz and ***Eric Alborg***, Regional Outreach Specialist, met with IHS Tucson Director ***George Bearpaw*** and toured (1) San Xavier Health Center Apedag Ju:ki Ki (Healing Rain House), (2) San Simon Health Center and (3) IHS Sells Hospital. The

Indian Health Service in Tucson runs the health care facilities on behalf of the Tohono O'odham Nation, formerly known as the Papago, and the Pascua Yaqui Tribe of Arizona. Health service for the Tohono O'odham is centered in Sells, Arizona, capital of the Tohono O'odham Reservation and hub of reservation life. Health centers are also located in the reservation communities of Santa Rosa and San Xavier. Health care in the Sells Service Unit is a combined effort of IHS and the Tohono O'odham Health Department, providing a comprehensive health program of inpatient services, ambulatory care, and community health services. Attendees included: ***Kevin Wade*** (Chief Information Officer), ***Randy Willard*** (Associate Director of Environmental Health and Engineering), ***George Bearpaw*** (Acting Director) and a member of the Tohono O'odham tribe.

California Consortium for Urban Indian Health and the Native American Health Center, Inc., December 14, 2010

RD Schultz met with ***Lyl Marden***, Director of the California Consortium for Urban Indian Health (CCUIH) and ***D'Shane Barnett***, Director of Planning and Policy for the Native American Health Center, Inc. to discuss working with California's tribes. California is in a unique position of representing over 1/3 of urban health clinics in the state and has a consortium of 8 urban Indian health care clinics and 3 referral centers in the state. (D'Shane Barnett will assume the role of Executive Director of the National Council of Urban Indian Health (NCUIH)).

United States Department of Health & Human Services
2010 Annual Tribal Consultation Report

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HIGHLIGHTS OF REGION-SPECIFIC ACCOMPLISHMENTS

- ***RD Johnson*** joined the Alaska Access to Healthcare Task Force (as called for in US Senator Begich's language in the Affordable Care Act) and HHS Central Office in a four day visit to Alaska that included visits to the following sites and meetings with tribal leaders and representatives: Central Peninsula Hospital in Soldotna, AK; Bassett Army Community Hospital in Ft Wainwright, AK; Fairbanks Memorial Hospital, the Denali Center, and Chief Andrew Isaac Health Center in Fairbanks, AK; Kanakanak Hospital (Bristol Bay Area Health Corporation) in Dillingham, AK; Togiak Clinic in Togiak, AK; Aleknagik, AK; Bethel Hospital (Yukon - Kuskokwim Health Corporation) and the Tundra Swan Inhalant Abuse Treatment Center in Bethel, AK; and Mountain Village Sub-Regional Clinic in Mountain Village, AK.

- ***RD Johnson*** participated in the Eastern Aleutian Islands Tribal Health Fair ferry tour, which was the first time an RD has been invited to participate in this event. The ferry stopped in Sand Point, King Cove, Cold Bay, False Pass, Akutan, and Dutch Harbor, AK.

- ***RD Johnson*** has visited with over 170 tribal leaders and representatives during her five trips (each) to Alaska and Oregon and her trip to Idaho.

-

SUMMARY OF REGIONAL CONSULTATION SESSIONS

Tribal Consultation Session, Seattle, Washington, March 23, 2010

RD Johnson hosted a Tribal Consultation Session for tribes in the Idaho, Oregon, and Washington states. There were 76 participants representing 26 tribes and topics of discussion included HHS Tribal Consultation Policy; HHS Regional Consultation Format; HHS Agency Tribal Consultation Policies; and HHS Tribal Advisory Committees. Attendance included: ***Anne Filipic***, Deputy Director for the Office of Intergovernmental Affairs and ***Andy Joseph Jr***., Colville Tribal Council Member and Chair of the Northwest Portland Area Indian Health Board (NPAIHB).

The top 5 National issues of concern were

1. Improve HHS' compliance with its Tribal Consultation Policy
2. Increase IHS funding for programs. Funding levels have remained relatively constant but the population is growing
3. Increase funding and make changes to Human Services Programs
4. Improve coordination of services for Tribal Veterans
5. Assist Tribes in equalizing inequities across the country

The top 5 Region specific issues of concern were

1. Continue to improve and build solid relationships between states and tribes and between county governments and tribes
2. Increase resources for substance abuse and behavioral health treatment for tribes
3. With state budgets in distress, the possible threat of subcontracting key programs, which could undermine the nation-to-nation relationship is of concern
4. Increase options for long term care within or close to tribal communities
5. Improve distribution of H1N1 vaccine for tribes.

Regional Tribal Consultation Session, Anchorage, Alaska, March 24, 2010

RD Johnson hosted a Tribal Consultation Session for the villages of Alaska. There were 55 participants representing 22 tribal governments. RD Johnson discussed the HHS Tribal Consultation Policy, HHS Regional Consultation Format, HHS Agency Tribal Consultation Policies and the HHS Tribal Advisory Committees. Attendance included: ***Lincoln Bean***, Chair of the Alaska Native Health Board, ***Anne Filipic***, Deputy Director for the Office of Intergovernmental Affairs.

The top 5 National issues of concern were:

1. Improve HHS' consultation and communication with the Tribes
2. Improve HHS' support of Tribal Self Governance in Alaska
3. Continue improvement of IHS systems and funding
4. Increase facility funding sustainability
5. Increase program funding

The top 5 Region specific issues of concern were:

1. Increase behavioral health funding and services including: suicide, domestic violence, sexual assault, child abuse, child neglect and methamphetamine prevention and treatment
2. Strengthen Tribal health facilities' and providers' ability to participate with Electronic Health Records
3. Improve prevention and treatment services for cancer, diabetes, heart disease, and obesity

4. Improve workforce shortages which are at a critical level
5. Increase options for long term care within or close to tribal communities.

Consolidated Report & Progress on Issues

The consolidated (Seattle and Anchorage Consultations) report was forwarded to the tribes on July 13, with the final report distributed on August 4, 2010. During the first quarterly Tribal Consultation Follow-up Conference Call (Oct 12, 2010), **RD Johnson** was encouraged by progress on issues noted in the Implementation Plan and encouraged all participants to bring issues forward in an ongoing way throughout the year. RD Johnson specifically noted the following updates:

1. SAMHSA has committed to providing a regional representative in 2011.
2. Regarding H1N1 vaccine distribution, Regional Health Administrator RADM ***Patrick O'Carroll*** has ongoing meetings with State Health Officials to monitor this issue and RD Johnson communicates with ***Mary Selecky,*** Washington Department of Health Secretary.

REGIONAL VISITS TO TRIBES

February 5, 2010. Northwest Portland Area Indian Health Board. ***RD Johnson*** met ***with Joe Finkbonner***, Executive Director, Northwest Portland Area Indian Health Board.

February 22-25, 2010. Alaska Native Health Board, Juneau, Alaska. ***RD Johnson*** spoke at the Alaska Native Health Board's Mega Meeting and met with the Indian Health Service, Tribal leaders and the State of Alaska. RD Johnson met with ***Evangelyn Dotomain,*** Executive Director of the Alaska Native Health Board; ***Chris Mandregan***, Director of Alaska Area IHS; ***Roald Helgesen,*** President of SouthEast Regional Health Consortium; ***Joel Neimeyer,*** Co-Chair of Denali Commission Federal; and ***COO Frank Sutton***. Tribal attendance included: ***Michael Christensen***, Executive Director, Eastern Aleutian Tribes; ***David Harrison***, Tribal Administrator, Native Village of Eklutna; and ***Lona Marioneaux-Ibanitoru***, Health Director, Yukon Flats Health Center.

March 4, 2010. Seattle Indian Health Board (SIHB). ***RD Johnson*** met with ***Ralph Forquera***, Executive Director of the SIHB.

February 25, 2010 Tribal TANF Single Point of Contact (SPOC) Meeting. ***RD Johnson*** met with at least 25 Tribal TANF Directors, including ***Rae Belle Whitcomb***, Bristol Bay Native Association Workforce Development.

March 19, 2010. Snoqualmie Tribe. ***RD Johnson*** met ***Matt Mattson***, Tribal Administrator.

March 24, 2010. Cook Inlet Tribal Council. ***RD Johnson*** met with ***Anne Filipic***, IGA Deputy Director; ***Stacey Ecoffey,*** Principal Advisor for Tribal Affairs; and staff from the Cook Inlet Tribal Council including ***Carrie McMillan***, ***Lisa Rieger***.

May 8, 2010. Seattle Indian Health Board. ***RD Johnson*** participated in the Seattle Indian Health Board's "Honoring the Gift of Tradition" Pow Wow and provided welcoming remarks of the SIHB's 40th Anniversary and accomplishments in smoking cessation.

May 19, 2010. Affiliated Tribes of Northwest Indians. ***RD Johnson*** spoke at the Affiliated Tribes of Northwest Indians mid-year meeting in Grand Ronde as part of the Health

System Panel on IHCIA and ACA implementation. She met with ***Julia Davis Wheeler***, Nez Perce Tribe (Idaho) Councilwoman; ***Joe Finkbonner***, Executive Director, ***Jim Roberts***, Policy Analyst, ***Andy Joseph***, Chair, Northwest Portland Area Indian Health Board; and with ***Doni Wilder***, Indian Health Service Portland Area Director. RD Johnson also met with ***John Stephens*** of the Swinomish Tribal Community and ***Marilyn Scott*** of the Upper Skagit.

June 7-12, 2010. Eastern Aleutian Islands. ***RD Johnson*** participated in the Eastern Aleutian Islands Tribal Health Fair ferry tour which was the first time an RD has been invited to participate in this event. The ferry left from Homer, AK, and stopped in Sand Point, King Cove, Cold Bay, False Pass, Akutan, and Dutch Harbor. Health Fairs were held at each location. This was a great learning opportunity for RD Johnson. She met many tribal members and listened to their issues and concerns. Health concerns included obesity, smoking, and diabetes.

July 6, 2010. Stillaguamish Tribe. ***RD Johnson*** met with ***Seh Welch***, Executive Director for the Stillaguamish Tribe discussing the needs of the Tribe, particularly around Methadone treatment (206 are on a waiting list), opportunities for partnering with CHCs and the progress of Consultation.

July 30, 2010. Confederated Tribes of Warm Springs. ***RD Johnson*** traveled to Warm Springs Reservation with ***Doni Wilder***, IHS Portland Area Director. They toured the health clinic and met with the IHS and Confederated Tribes of the Warm Springs Reservation Joint Health Commission.

August 3, 2010. Seattle Indian Health Board. ***RD Johnson*** met with ***Sharyne Thornton***, SIHB Board Member and cultural competency and health disparities consultant, regarding opportunities for Tribes within the ACA.

August 7-11, 2010. Alaska Tribal Visits. ***RD Johnson*** traveled to Alaska to participate in the Alaska Access to Healthcare Task Force site visits and HHS Central Office visits to tribal governments /organizations. She visited the following sites: Central Peninsula Hospital in Soldotna, AK; Bassett Army Community Hospital in Ft Wainwright, AK; Fairbanks Memorial Hospital, the Denali Center, and Chief Andrew Isaac Health Center in Fairbanks, AK; Kanakanak Hospital (Bristol Bay Area Health Corporation) in Dillingham, AK; Togiak Clinic in Togiak, AK; Aleknagik, AK; Bethel Hospital (Yukon - Kuskokwim Health Corporation) and the Tundra Swan Inhalant Abuse Treatment Center in Bethel, AK; and Mountain Village Sub-Regional Clinic in Mountain Village, AK. Issues and concerns raised included: dental care, suicide clusters, need for mental and behavioral health care, and hospice / elder care.

August 12, 2010. Alaska Native Health Board. ***RD Johnson*** hosted an HHS Tribal Resource Day as part of the Alaska Native Health Board's twice yearly Mega-Meeting. Agenda topics included: White House update by ***Jodi Gillette***, Deputy Associate Director WH Office of Intergovernmental Affairs; IHS Update by ***Dr. Yvette Roubideaux***, Director of IHS; Substance Abuse & Mental Health Services Administration Update by ***Pamela Hyde***, Administrator; Administration for Children and Families update by ***Lillian Sparks***, Commissioner for the Administration for Native Americans; CDC Update by ***Melanie Duckworth***, Public Health Advisor for CDC; and ***Marilyn Tavenner***, Principal Deputy Administrator for CMS held a CMS Alaska Access to Healthcare Task Force Stakeholders Roundtable.

August 13, 2010. Southcentral Foundation. ***RD Johnson*** met ***with Dr. Ted Mala***, Director of Tribal Relations, and toured their Anchorage facility.

September 24, 2010. Nez Perce Tribe. ***RD Johnson*** visited the Nez Perce Tribe in Lapwai, ID meeting with ***Julia Davis-Wheeler***, Member of Nez Perce Tribal Executive Committee, and ***Lisa Guzman***, Executive Director of Nimiipuu Health, and toured their clinic.

September 27-30, 2010. Region 10 Tribal TANF Conference. ***RD Johnson*** spoke at the Region 10 TANF Conference. Approximately 150 managers and staff from regional Tribal TANF programs gathered for this 3-day conference. This was the largest number gathering since ACF started hosting this conference. RD Johnson spoke about her visits to tribes and her participation in the Alaska Tribal TANF Conference held in Juneau. Following the comments she had heard during her Juneau trip, she met with state officials and was able to move along some changes. She encouraged all to shed light on what's not working and work together to fix it.

September 27, 2010. Tulalip Tribe. ***RD Johnson*** met with ***Karen Fryberg***, Tulalip Tribal Health Director and toured the Tribal Health Clinic.

October 27, 2010. Klamath Tribe. ***RD Johnson*** met with ***Leroy Jackson***, Health General Manager for Klamath Tribal Health & Family Services, and toured Wemble House, a youth treatment facility.

November 18, 2010. HUD Federal Partners Meeting. ***EO Bobbie Mowery*** represented RD Susan Johnson at a meeting called by HUD to share information about each federal agency's programs and areas where the agencies can better coordinate efforts in Indian Country. Participants included: HUD, HHS / OS, USDA Rural Development, DOI / BIA, HHS / IHS, DOJ, EPA, DHS / FEMA, Washington State Housing Finance Commission, Economic Development Administration, Common Ground, and Rural Communities Assistance Corporation.

December 15, 2010. Seattle Indian Health Board. ***RD Susan Johnson*** met with ***Ralph Forquera***, Executive Director for SIHB.

United States Department of Health and Human Services

2010 HHS Divisions

United States Department of Health and Human Services, HHS Division Directors

Left to Right: ***Ellen Murray*** (ASFR), ***David Hansell*** (ACF), ***Kathy Greenlee*** (AoA), ***Dr. Carolyn Clancy*** (AHRQ), ***Thomas Frieden*** (CDC, ATSDR), ***Dr. Donald Berwick*** (CMS), ***Secretary of Health Kathleen Sebelius***, ***Dr. Margaret Hamburg*** (FDA), ***Dr. Mary Wakefield*** (HRSA), ***Dr. Yvette Roubideaux*** (IHS), ***Dr. Francis Collins*** (NIH), ***Daniel Levinson*** (Inspector General, OIG), ***Pamela Hyde, J.D.*** (SAMHSA)

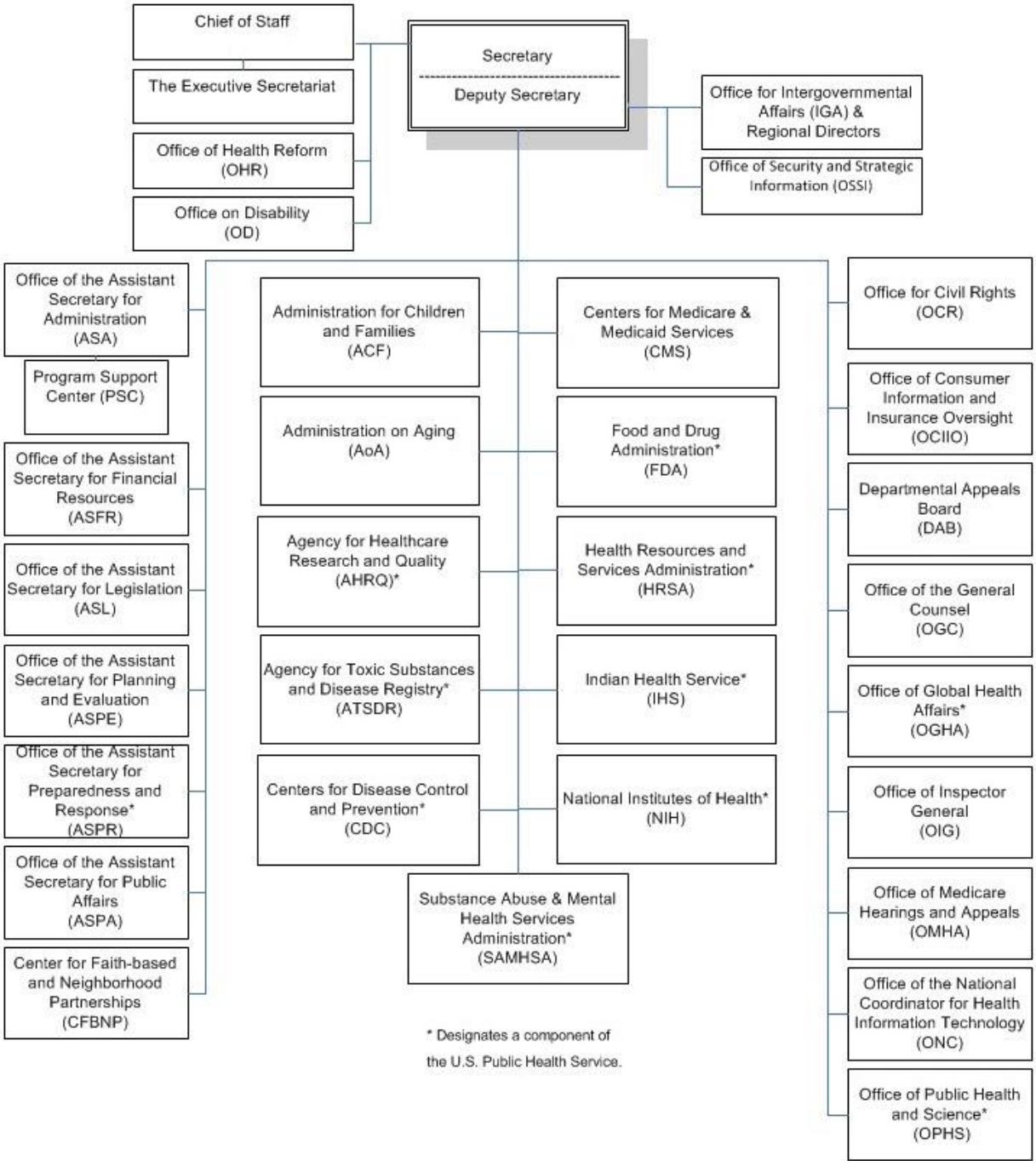

Figure: U.S. Department of Health and Human Services Organizational Chart

United States Department of Health and Human Services

Administration for Children and Families (ACF)

The Administration for Children and Families, within the Department of Health and Human Services is responsible for Federal programs that promote the economic and social well-being of families, children, individuals, and communities. ACF programs aim to achieve the following: families and individuals empowered to increase their own economic independence and productivity; strong, healthy, supportive communities that have a positive impact on the quality of life and the development of children; partnerships with individuals, front-line service providers, communities, American Indian Tribes, Native communities, States, and Congress that enable solutions which transcend traditional agency boundaries; services planned, reformed, and integrated to improve needed access; and a strong commitment to working with people with developmental disabilities, refugees, and migrants to address their needs, strengths, and abilities.

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HIGHLIGHTS OF DIVISION SPECIFIC ACCOMPLISHMENTS/ACTIVITIES TARGETED TOWARD AMERICAN INDIAN/ALASKA NATIVES (AI/AN)

- ACF held its first Tribal Consultation session in 5 years to obtain input from tribal leaders on the draft ACF Tribal Consultation policy. The final policy is expected to be issued in early 2011.
- ACF created a Native American Affairs Advisory Council (NAAAC) to support the Assistant Secretary for Children and Families, the Commissioner for the Administration for Native Americans, and all ACF program and regional offices that provide services to Native Americans.
- ACF created a tribal webpage to serve as an all encompassing site for tribally related events and publications.
- The Office of Head Start (OHS) scheduled eight Head Start Tribal Consultations in each of the Regions for the purpose of better meeting the needs of AI/AN children and families and to inform strategies for improving the delivery of Head Start services in the geographic locations where AI/AN children and families reside.

DIVISION SPECIFIC ACTIVITIES

Administration on Children, Youth, and Families (ACYF) - Children's Bureau (CB)

The Children's Bureau continued its outreach to Tribes, particularly with regard to Public Law 110-351, the Fostering Connections to Success and Increasing Adoptions Act of 2008, which authorized Tribes to apply to receive direct funding under title IV-E of the Social Security Act. Beginning October 1, 2009, Tribes, tribal organizations, and tribal consortia (hereafter, Tribes) became eligible to receive direct funding from the Federal government for title IV-E programs that provide entitlement funding for foster care, adoption assistance, guardianship assistance payments, and related administrative expenses for eligible children. Before that date, Tribes had access to these funds only through negotiated agreements with States. The Children's Bureau has worked to ensure that Tribes understand the title IV-E program and issues that Tribes will need to explore in considering whether to apply to receive direct funding under the program. No Tribe has yet been approved to operate a title IV-E program. One Tribe, Port Gamble S'Klallam, Kingston, Washington, submitted a title IV-E plan to directly operate a title IV-E program. Staff in the Children's Bureau Region X office in Seattle worked with the Tribe to achieve an approvable plan. No other Tribe has yet submitted a plan.

The Fostering Connections to Success and Increasing Adoptions Act of 2008 provided for grants of up to $300,000 to be used over a 2-year budget period for Tribes to develop an approvable title IV-E plan. A grantee meeting was held in Washington, D.C., in March 2010, for these grantees. The first round of grantees included:

- Confederated Salish and Kootenai Tribes, Pablo, Montana;
- Keweenaw Bay Indian Community, Baraga, Michigan;
- Navajo Nation, Window Rock, Arizona;
- Sac and Fox Nation, Stroud, Oklahoma;
- Tohono O'odham, Sells, Arizona;
- Washoe Tribe of Nevada and California, Gardnerville, Nevada; and
- Confederated Tribe of Siletz Indians, Siletz, Oregon.

A second round of grants was awarded September 30, 2010 to:

- The Chickasaw Nation, Ada, Oklahoma;
- Lummi Nation, Bellingham, Washington;
- The Shoshone-Bannock Tribes, Fort Hall, Idaho; and
- Yurok Tribe, Klamath, California.

The Children's Bureau issued a program instruction, ACYF-CB-PI-10-08, on April 20, 2010, providing guidance to Tribes on actions they were required to take for the June 30, 2010, submission of the Annual Progress and Services Report (APSR) required under title IV-B of the Social Security Act (the Act) for the Stephanie Tubbs Jones Child Welfare Services and Promoting Safe and Stable Families (PSSF) Programs; the Chafee Foster Care Independence Program (CFCIP); the Education and Training Vouchers (ETV) program; and with the inclusion of instructions for submission of budget requests and expenditure reports. Fiscal Year 2010 was the first year in which Tribes that have a title IV-E agreement with the State or are direct recipients of title IV-E had the option of applying to receive direct funding under the Chafee Foster Care Independence Program (four Tribes were awarded funding) and the Education and Training Vouchers Program (three Tribes were awarded funding).

Eileen West participated in a Bureau of Indian Affairs meeting the week of April 20, 2010, in Billings, Montana, where presentations were made on the title IV-E programs with several sessions on specific parts of the plan requirements. There were approximately 170 participants including tribal representatives from Montana and Wyoming, and representatives from the offices of U.S. Senator Max Baucus and U.S. Representative Jon Tester. Another session, presented by Eric Busch, from the Children's Bureau Region VIII office in Denver, Colorado, focused on the requirements for Tribes who intend to apply for funding under title IV-B.

Tribal title IV-E development grantees and other Tribes interested in a title IV-E program participated in a call on June 15, 2010, on a proposed new financial form, the Title IV-E Programs Quarterly Financial Report Form (CB-496). Changes were necessary to accommodate new provisions such as the kinship guardianship program which is open to Tribes and States and to address specific tribal provisions such as in-kind match. The purpose and use of the forms was reviewed and comments were solicited from the Tribes. The Office of Management and Budget published a notice in the *Federal Register*, Vol. 75, No. 95, Tuesday, May 18, 2010, soliciting comments on the form.

A request for Public Comment and Consultation meetings on the Adoption and Foster Care Analysis and Reporting System (AFCARS) was published July 23, 2010, in the *Federal Register*, Volume 75, Number 141. Tribal comments were being solicited regarding modifications to the requirements for title IV-E agencies to collect and report data on children in out-of-home care and in subsidized adoption or guardianship arrangements. Two consultation sessions were held at the data conference. Additional consultation sessions were held in Dallas, Texas (September 5, 2010), Kansas City, Missouri (September 17, 2010), Denver, Colorado (September 22, 2010), and Seattle, Washington (September 23, 2010).

During the period April through September 2010, Eileen West from Central Office and staff from the five respective Regional Offices visited the seven tribal title IV-E

Development Plan grantees. Discussion centered on requirements for an approvable title IV-E plan (i.e., foster care, adoption assistance and guardianship assistance programs) and technical assistance needs. Tribes were advised of the availability of the Children's Bureau's National Resource Centers and how to access them, the electronic information library (Child Welfare Information Gateway) and examples of types of information available and the technical assistance the Children's Bureau regional offices can provide regarding title IV-E claiming. These visits were well received and Tribes seemed appreciative that someone from Washington, D.C., came to visit them on-site.

In September 2010, the Children's Bureau's National Resource Center (NRC) for Tribes completed its first year under a 5-year cooperative agreement. A major activity of the first year was to conduct an assessment of tribal child welfare systems to better understand and appropriately serve tribal communities.

Region II

- Continually provided updated information and guidance to Tribes regarding title IV-B and IV-E programs and provisions related to the Fostering Connections law that allows Tribes to become title IV-E entities.
- Provided assistance and guidance to the Seneca Nation of Indians to help them become the first Federally approved tribal title IV-B program in the Region.
- Continued to work with the St. Regis Mohawk Tribe to assist in their pursuit of title IV-B programming and sustaining their title IV-E tribal agreement with New York State.
- Provided information and guidance on provisions of the Affordable Health Care Act legislation.
- Continued to partner with Tribes that have not pursued Federal resources because of Tribal Council policies to find ways to garner needed services for children and families.

Region X

- In May 2010, the Children's Bureau Regional Office X in Seattle hosted a regional tribal meeting with over 30 Tribes from the States in that region, along with representatives from the Washington State Governor's office. The focus was on tribal title IV-B and IV-E programs. The Tribes had positive comments about the meeting and requested a regional meeting for next year.

ACYF – Families and Youth Services Bureau (FYSB)

Inter-Agency HHS-Department of Justice (DOJ) Workgroup.

The HHS-DOJ Tribal Workgroup has been meeting on a monthly basis. The workgroup is chaired by the former Director of the Intra-Departmental Council on Native American Affairs. Participants include FYSB (primarily the Family Violence Prevention and Services Act (FVPSA) Program and Mentoring Children of Prisoners (MCP) programs), DOJ, the Office of Violence Against Women (OVW), and the Substance Abuse and Mental Health Services Administration (SAMHSA). The main focus of this workgroup is to discuss potential coordination of TA efforts, particularly in the areas of tribal courts and justice, youth victims of crime, family/youth violence

issues, youth mentoring, and youth programs in general, as well as potential collaboration efforts.

White House Working Group on Youth Issues

In 2010, the White House convened a working group on youth issues, led by DOJ, with representatives from a wide range of government agencies. ACYF was represented by both FYSB and CB, and the report is currently being finalized.

Family Violence Prevention and Services Act Program (FVPSA)

Through a 10 percent set-aside for Indian Tribes, Alaska Native Villages, and Tribal organizations, FVPSA supports emergency shelter and related assistance for victims of domestic violence and their dependents. In FY 2010, 205 Federally recognized Tribes, Alaskan Native Villages, and tribal organizations received FVPSA grants totaling over $12.9 million, ranging from $26,232 to $2,295,289.

Technical Assistance (TA) Support Services

The FVPSA Program has increased TA support through monthly TA calls, on-site monitoring, webinars, peer mentoring meetings, and email. These efforts were intended to assist grantees in establishing and maintaining their domestic violence programs, to encourage collaboration, and to enhance their awareness and responses to FVPSA's programmatic and financial obligations. Through the support provided, the FVPSA Program has increased the number of Tribes reporting in a more unified, substantive, and timely manner, and increased collaboration amongst peers.

Peer Mentoring

In April 2010, the FVPSA program sponsored and facilitated its pilot Tribal Peer Mentoring meeting. It consisted of 15 individuals from five tribal domestic violence and sexual assault programs in Maine, New York, and Vermont. The intent of peer mentoring is to discuss key issues specific to tribal organizations and their communities and to allow peers the opportunity to utilize expertise from peers with experience addressing similar issues. In April, the topics of discussion included: (1) training for law enforcement; (2) emerging issues in Tribal communities; (3) maximizing resources beyond the FVPSA grant; (4) strengths, gaps and weaknesses of TA currently provided; (5) advocacy; and (6) relationships with programs on a local level. The meeting was piloted successfully and the next session is expected to convene in February 2011. Since the peer mentoring meeting, the FVPSA program has continued direct communications and support; in collaboration with Sacred Circle, the Tribal National Resource Center, to provide more useful tools to domestic violence advocates.

Reporting

In FY 2008, FYSB worked with tribal representatives to assess the program reporting procedures and outcome measures for FVPSA tribal grantees. The reporting requirements were developed and the standardized program performance reporting form (SF-PPR) and definitions were introduced to the tribal grantees in 2008. From October 2008 through June 2009, the tribal grantees received training on how to collect and report on the required data elements via conferences, webinars, and conference calls. Use of the SF-PPR was made mandatory for the FY 2009 reporting cycle. FVPSA continues to provide SF-PPR reporting requirements training via telephone and webinar. By December 2010, FVPSA anticipates the

ability to capture useful information, using data compiled from the reports, to provide a more comprehensive and data-driven assessment of the FVPSA tribal programs, as well as the kind of support services provided and the number of individuals served in tribal communities annually.

Tribal Community of Practice

The FVPSA Tribal Community of Practice is an Internet-based tool, and it was developed by the FVPSA Program to support grantees' need to have a way to communicate with other FVPSA grantees, as well as a place to receive Federal updates and to be able to discuss domestic violence issues and trends within the tribal communities. The community of practice is also used to post reminders of reports that are due, to post calendar events, to provide relevant updates, and to share cross-agency news, funding opportunities, and resources. The Community of Practice went live August 2010.

Runaway and Homeless Youth Programs (RHY)

Runaway and Homeless Youth Programs (Region X) — Alaska T/TA Initiative

The Family and Youth Services Bureau (FYSB) have an Alaska T/TA Initiative underway to address some of the unique challenges faced by grantees providing services in RHY programs. One major challenge is that Alaska grantees are unable to participate in most lower 48 T/TA workshops and training opportunities, and there are specific unique T/TA grantee needs that can be most effectively addressed in Alaska. The Alaska Initiative began the end of last fiscal year, with an onsite T/TA assessment of all four (now five) Alaska grantees. The follow-up FY 2010 T/TA response is now being developed in a close partnership involving Region X, FYSB, and the FYSB-funded national RHY T/TA Contractor (RHYTTAC).

Defining RHY in Tribal communities

In 2010, program staff and our RHYTTAC have begun working more closely with tribal grantees to better define what Runaway and Homeless Youth means in Native communities, especially on Indian reservations.

Native American Protection and Advocacy (P&A) Agency

ADD funds one P&A (Native American Disability Law Center, Inc.) which covers the Four Corners region of Arizona, New Mexico, Utah, and Colorado, and serves individuals of the Navajo Nation and the Hopi Reservation. This P&A received $205,808 in FY10.

Investigation/Monitoring Abuse and Neglect:

The Law Center monitored a total of 12 cases involving the abuse or neglect of adults and children with disabilities, five of these cases involved clients eligible for Protection and Advocacy Systems – Developmental Disabilities (PADD) services. The majority of these cases involved children taken into custody by the Navajo Nation Division of Social Services (DSS), but several of the cases involved adults with disabilities living in institutions. The Law Center monitors the cases to ensure that DSS fully investigates and addresses incidents of abuse and neglect.

North Dakota Protection & Advocacy (P&A) Agency

Outreach to tribal populations: A unique feature of the P&A Project is that it includes nine Regional Offices distributed evenly across North Dakota in Williston, Belcourt,

Devils Lake, Jamestown, Minot, Grand Forks, Fargo, and Bismarck, one of which is located on the Turtle Mountain Reservation. Similarly, another Native American advocate located in the Bismarck office makes weekly visits to the Standing Rock Reservation to address the special advocacy issues there.
The P&A Project held a public forum in July to discuss the priorities. Six sites were connected using the State's Interactive Video Network (IVN), including a site on one of North Dakota's Native American reservations.

The P&A Project's extensive outreach to the Native Americans is partly because of the high number of Regional Offices, including one on the Turtle Mountain Reservation, but also because the P&A has on staff two Native American advocates who work hard to create a presence on the reservations. The result is the P&A Project has successfully served Native Americans in North Dakota in somewhat larger proportion than their numbers in the state.

South Dakota University Center on DD (UCEDD)

The UCEDD Center for Disabilities/University of South Dakota (CD/USD) administers two developmental clinics on the reservations of Cheyenne River and Pine Ridge. These clinics address health, nutrition, and developmental needs of children from birth through 5 years of age.

Pediatric professionals from CD/USD fly by charter plane once a month to work with local professionals to implement these clinics. Two teams provide a comprehensive evaluation to determine if the child may be eligible for early intervention services. Each team works through an arena-based style and evaluates motor development, communication, cognition, and adaptive behavior. In addition, each child receives a nutritional consultation. Quarterly, an audiologist provides hearing examinations to the children that appear to be at-risk for a hearing loss. On a quarterly basis, a developmental pediatrician also sees children who have been through the developmental clinic but still have questions regarding health/development that need to be addressed.

Approximately eight children are seen at each monthly clinic. Prior to the clinics, local staff provides developmental screenings in the local reservation communities. Children that appear at-risk as a result of the screening process are referred into the clinic. After the clinic, the local staff along with the birth–to-3 Service Coordinator for the area provides a follow-up visit to the family. At this visit all of the information from the clinic is shared and appropriate releases are signed. If the child qualifies and if the family wants it, the child is then connected to the Individualized Family Services Plan (IFSP) or Individualized Education Plan (IEP) and a service plan is developed. Children qualifying for services are usually receiving services within 2 weeks and always within 30 days.

Many products have been developed in conjunction with these clinics. Some of the products have been translated into Lakota depending on the wishes of the local advisory committee.

Dakotas' Fetal Alcohol Spectrum (FAS) Prevention Project: This project is a collaborative effort between university representatives from South Dakota and North Dakota in partnership with tribal communities and the Departments of Health from each State. One purpose of this project is to implement community-based prevention efforts to lower alcohol-exposed pregnancies. The project is also focused

on establishing an FAS prevalence rate in the Dakotas and monitoring the number of individuals diagnosed with Fetal Alcohol Spectrum Disorders (FASD).

Administration for Native Americans (ANA)

ANA promotes the goal of economic and social self-sufficiency for American Indians, Alaska Natives, Native Hawaiians, and the Native peoples of Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

ANA had a busy and successful year in 2010. One of the most important results from the year is that the President appointed, and the Senate confirmed, Lillian Sparks as the Commissioner of ANA. The political leadership enabled ANA to establish partnerships, work with the administration on key tribal issues, and better support communities through urgent funding for victims of natural disasters.

- ANA increased community outreach and community communication. Since taking office, the Commissioner has visited Tribes and Native organizations in each of ANA's four regions, including the Secretary's trip to Alaska and the Alaska Native Health Board meeting. The Commissioner also held monthly calls with all ANA grantees, re-established the ANA newsletter, and e-mailed communities important announcements on behalf of ANA, ACF, and HHS. These announcements reached over 700 Native people and organizations.
- ANA and OCS partnered to promote the Assets for Independence Program to Native communities. As a result of their efforts, ANA provided six pre-application sessions and made three new awards (two of the grantees attended the pre-application trainings).
- ANA responded to the tsunami that impacted American Samoa on September 29, 2009. For comparison, the land area of American Samoa is 72 square miles, slightly more than Washington, D.C. In that small area, 32 people were killed and 277 homes, schools, businesses, and transportation systems were destroyed as a result of the devastating tsunami. Five urgent single-source grants totaling $312,605 were funded to mitigate the impact of the devastation.

In FY 2010, ANA implemented two types of free training and technical assistance to (1) further the general development of communities, and (2) assist in the development of projects specifically designed for ANA resources.

Project Development Training

The project planning and development trainings are designed to provide prospective ANA applicants with skills to plan successful community development projects. Participants learn how to (1) work with their community and key partners to identify and document specific community problems that stand in the way of meeting community goals; (2) create a project work plan to address those problems and attain community goals; (3) develop measurable outcomes and impacts to the community; and (4) determine the level of resources and funding needed to implement the project.

Electronic Training and Technical Assistance & Pre-Application Training

The pre-application trainings are designed to provide prospective ANA applicants with "nuts and bolts" information on the Federal application process and the ANA Funding Announcements for Social and Economic Development Strategies (SEDS), Native Language Preservation and Maintenance, and Environmental Regulatory

Enhancement. It is expected that at this training the applicant will have attended the project development training and have 70 percent of the application written.

ANA Project Funding Summary

- ANA administers approximately 220 projects annually.
- The FY 2010 demand for project funding of new awards exceeded $210 million.
- Of the 389 new grant applications received, 19 percent received funding.
- ANA awarded 74 new competitive grants totaling $14,262,886, and 135 continuation grants totaling $27,336,529.
- ANA, under its Esther Martinez Initiative, funded Native Language projects that focused on language immersion, the building of language nests, and the building of language schools. In FY 2010, ANA funded seven new awards and seven continuation awards totaling $3.4 million. Totals of all new grants were awarded in the following program areas:
    - Social and Economic Development Strategies (SEDS): 22 awards
    - SEDS – Special Initiative: 16 awards
    - Language Preservation and Maintenance: 23 awards
    - Language – Esther Martinez Initiative: 7 awards
    - Environmental Regulatory Enhancement: 6 awards
- The average grant amount was $199,040.
- The location breakdown of FY 2010 grants is as follows:
    - Alaska: 12.92 percent
    - Pacific Basin: 13.88 percent
    - Lower 48 States: 73.21 percent
- 216 Peer Panel Reviewers evaluated 389 FY 2010 ANA grant applications.

Office of Child Care (OCC)

The Office of Child Care (OCC), formerly known as the Child Care Bureau, administers the Child Care and Development Fund (CCDF) (also known as the Child Care and Development Block Grant) by overseeing the implementation of State, Territorial, and Tribal CCDF programs. OCC provides support in establishing child care policies and programs that take advantage of the flexibility that CCDF offers and that respond to the needs of low-income working families. In addition, OCC provides a variety of technical assistance and professional development services targeted to meet the needs of CCDF administrators in the States, Territories, and Tribes.

Region II: Region II has fostered a working relationship between New York State and the two Tribal Nations that are funded under CCDF – the Seneca Nation of Indians and the St. Regis Mohawk Tribe. This included joint training of tribal child care staff with New York State staff on issues such as inclusion of children with special needs, health and safety, and administration of medications. The St. Regis Mohawk Tribe was able to obtain an on-site early intervention provider to help serve Native children.

Region IV: In Region IV, the OCC and OHS hosted a joint roundtable discussion with State/Tribal Child Care Administrators, Regional/Central Office ACF staff, and State Head Start Administrators. The event was held May 25-27, 2010, with 81 registered participants. The goal for the meeting was to promote the creation of an integrated system to support quality early care and education in the Region IV states. The topics discussed included information on early childhood licensing, data collection, health and safety, obesity, emergency preparedness, existing child care research, current collaborative efforts between Child Care and Head Start grantees, American Recovery

and Reinvestment Act (ARRA) spending, and the implementation of new initiatives in training and technical assistance which supports States and Tribes. One of the outcomes from the meeting was the creation of a program guide titled "State by State Head Start Collaborations," published by the Region IV Office of Head Start. This guide provides a foundation for future efforts by setting goals and assigning responsibilities for plan implementation.

Region V: Region V organized a "Policies and Procedures for Health, Safety and Quality" workshop for Tribal CCDF Administrators, which was held August 24-26, 2010, in Bloomington, Minnesota. The 3-day workshop focused on assisting administrators in developing and revising health and safety policies and improving the quality of tribal child care. Tribal administrators toured and observed three local, quality early childhood programs that participate in a Quality Rating System.

Region V supported the Michigan State/Tribal Collaboration Meeting on June 7-8, 2010, in Lansing, Michigan. The focus of this collaborative meeting was to determine common needs and issues among the Tribes in Michigan and to exchange individual tribal issues and concerns. It brought together Child Care and Development Fund (CCDF) and Head Start tribal administrators, other key tribal stakeholders within the State and Region V administrators.

Region VI: Region VI OCC and TriTAC held Tribal Technical Assistance workshops that focused on developing written policies and procedures for tribal programs. The first workshop was held in Dallas, Texas, on February 2-3, 2010, and the second workshop was held in Catoosa, Oklahoma, June 15-16, 2010. Approximately 40 Tribes attended the workshops. The primary goal of the workshop was to address the needs of tribal CCDF grantees regarding the development and refinement of tribal plans, policies, and procedures. Another goal was to provide participants with the opportunity to work on their plans and procedures with the support and assistance of tribal CCDF technical assistance providers and Regional Office staff members, and to facilitate the identification of training resources.

Region VII: Region VII supported a Tribal Resource Day in Kansas City, Kansas, held September 8-9, 2010. Regional Director of HHS, Judy Baker facilitated the sessions that were attended by the nine Region VII Tribes. The Affordable Care Act Overview and Impact on Tribal Healthcare was discussed as were issues raised at the recent Tribal Consultation in Albuquerque, New Mexico. Three successful tribal programs made presentations at the event: Santee Sioux Language Preservation, Winnebago Fatherhood is Sacred Program, and the Nebraska State Health Preparedness Program.

Region VIII: Region VIII conducted the Region VIII Tribal CCDF Policies and Procedures II training from April 13-15, 2010, in Denver, Colorado. The Region VIII OCC staff and TriTAC planned and facilitated the training. Tribal administrators utilized laptop computers to complete electronic documents on-site and to facilitate the hands-on training. Tribal attendees received training and technical assistance for developing and updating policies and procedures, and completed documents for implementation in their programs.

Region IX: Region IX OCC facilitated a Federal/State/Tribal Nevada Roundtable hosted by the Inter-Tribal Council of Nevada on June 22-23, 2010. Tribal participants included Child

Care, Head Start, and Child Welfare Administrators from five Nevada Tribes and the Inter-Tribal Council of Nevada. State participants included the State CCDF Administrator, the Head Start State Collaboration Office Director, the Aging and Disability Services Division/IDEA Part C Consultant from the Department of Health and Human Services, and the Tribal Liaison from the Department of Education. Information was presented and input was received on the Nevada Indian Education Strategic Plan, Early Childhood Education objectives, the Nevada IDEA-Part C recruitment efforts in tribal early childhood programs, and the formation of the Nevada Early Childhood Advisory Council. A notable outcome was the formation of a Nevada Tribal Early Childhood Education Advisory Committee to advise the Nevada State Early Childhood Advisory Council, which subsequently received funding from the Nevada Early Childhood Comprehensive Systems project to develop a plan, and commenced activities in October 2010.

Region IX OCC provided technical assistance to Coyote Valley Rancheria, Redding Rancheria, Pit River Tribe, Quartz Valley Rancheria, Karuk Tribe, Smith River Rancheria, and the Yurok Tribe. Region IX program staff went onsite to provide technical assistance on program development, grant funds tracking and reporting, and health and safety and quality training so these Tribes could enhance their CCDF programs and identify best practices that could be shared with other tribal programs.

Region X: On June 15-16, 2010, the Region X Office of Child Care in Seattle held a roundtable for the Region X Tribes in Washington, Oregon, and Idaho. The topics for the roundtable included CCDF fiscal administration; incorporating Northwest Native American Reading Curriculum, a research-based, culturally relevant, supplemental reading curriculum, into child care programs; and managing challenging behaviors of children and parents in the child care setting.

In FY 2010, the Region X Office of Child Care conducted quarterly conference calls with tribal CCDF grantees on topics related to child care subsidy management, health and safety standards, fiscal reporting, child counts, afterschool care, the ARRA, and Tribal/State CCDF coordination.

Office of Child Support Enforcement (OCSE)

OCSE Meeting at Nez Perce

Commissioner Vicki Turetsky met with tribal leaders and with tribal child support directors from several Region X Tribes at the Nez Perce Tribe to discuss pending OCSE policy initiatives, as well as OCSE plans for future consultations.

Visits with Tribal IV-D programs

Schedule permitting, Commissioner Vicki Turetsky meets with tribal child support program directors while she is traveling. She met with the Navajo Nation, the Oneida Tribe of Wisconsin, the Pueblo of Zuni, and the Winnebago Tribe of Nebraska.

Cherokee Nation Government to Government Relations Retreat

OCSE Deputy Commissioner Donna Bonar and Director, Division of Regional Operations, Roy Nix attended the Cherokee Nation Government-to-Government Relations Retreat in Tahlequah, Oklahoma. The retreat culminated with the annual Cherokee Nation Pow Wow and State of the Union address.

National Congress of American Indians Midyear Conference and Trade Show

OCSE Deputy Commissioner Donna Bonar met with tribal leaders and their delegates at the National Congress of American Indians Midyear Conference and Trade Show in Rapid City, South Dakota, to discuss plans for future consultations regarding long term maintenance and custodianship of the Model Tribal System and other child support policies that may affect tribal communities.

Office of Community Services (OCS)

ACF Resource Day and Tribal Consultation

ACF hosted a National ACF Tribal Consultation on Wednesday, September 29, 2010, in Washington, D.C. The meeting provided an opportunity for tribal leaders and representatives to comment on the draft ACF Tribal Consultation Policy. It also allowed tribal leaders to present their priorities and recommendations to ACF leadership, bureaus, and offices regarding tribal self-governance and other tribal issues. Dr. Yolanda J. Butler represented OCS in this information sharing session. OCS was also involved in the consultation by displaying an informational booth and participating in a panel discussion during the Resource Day on Tuesday, September 28, 2010.

OCS Tribal Website

In Spring 2010, OCS launched a tribal website specifically to highlight the tribal activities within OCS. It includes a mission statement for the OCS Tribal Workgroup and contact information for the workgroup members. There are also *Frequently Asked Questions* and tribal funding information from the various OCS programs. The address to the OCS Tribal Website is *www.acf.hhs.gov/programs/ocs/Tribal/index.html.*

National Energy and Utility Affordability Conference – LIHEAP

The National Energy and Utility Affordability Conference was held June 14-16, 2010, in San Antonio, Texas. It was a nationally-targeted conference for all Low Income Home Energy Assistance Program (LIHEAP) State directors, fuel vendors, and local providers. OCS provided four workshops especially geared to Tribes administering the LIHEAP. More than 25 Tribes participated. This was the largest turnout for tribal representatives to date for the annual energy assistance conference. Two workshops provided ten roundtable discussions that were repeated to allow participants to hear four different topics. These roundtable discussions were headed by experienced tribal LIHEAP coordinators and Federal staff who shared best practices and other LIHEAP program information with participants. On the final day, a workshop offering guidance for new coordinators was presented by Federal staff and tribal representatives from the Klamath Tribes in Oregon.

LIHEAP Tribal Grantee Call

The Division of Energy Assistance held a teleconference with Tribes on July 20, 2010, and August 17, 2010. The conference call was held to discuss two recent guidance issuances for LIHEAP grantees on Information Memorandum, LIHEAP-IM-2010-06, on Social Security Numbers, and on Action Transmittal, LIHEAP-AT-2010-06, on the Program Integrity Assessment Supplement. A total of 46 tribal grantees participated in the teleconference.

Strengthening Community Fund – Tribal Site Visit

On May 4, 2010, two Program Specialists from the Strengthening Communities Fund conducted a site visit at the First Nations Development Institute in Longmont, Colorado. This is a tribal organization that targets 22 reservations within eight states in the Upper Peninsula, Southwest, and Oklahoma. The goal of the site visit was to monitor progress and compliance, provide technical assistance, and learn stories of community impact.

Technical Assistance

Community Services Block Grant (CSBG) Program Specialists provided technical assistance to Tribes and tribal organizations via quarterly conference calls and emails. The calls took place once per fiscal year quarter and served as a regular update regarding CSBG activities and issues. These calls allowed the Tribes to ask questions regarding CSBG funding, and to hear questions and comments from other Tribes in a conference setting. The calls encouraged information sharing to maintain positive relationships with OCS tribal grantees.

Assets for Independence (AFI) Program Partners with ANA

In FY 2010, OCS' AFI Program provided funding to ANA to conduct outreach in Native communities with the goals of increasing access to and awareness of asset building strategies in Native communities. With support from OCS, ANA developed an AFI pre-application training curriculum for Tribes and Native groups interested in building financial education and Individual Development Account (IDA) projects in their communities. ANA conducted six AFI pre-application trainings in the following cities:

- St. Louis, Missouri: April 20-22, 2010
- Reno, Nevada: April 27-29, 2010
- Honolulu, Hawaii: July 6-8, 2010
- Anchorage, Alaska: July 20-22, 2010
- Seattle, Washington: July 27-29, 2010
- Minneapolis, Minnesota: August 3-5, 2010

ANA provided electronic technical assistance to five Tribes following the trainings. The trainings and technical assistance resulted in two additional AFI applications from Tribes in FY 2010. Additionally, the AFI program developed a section of the AFI Resource Center web page dedicated to asset building in Native communities, and ANA and OCS collaborated to produce two articles for this section.

AFI Outreach Workshop – Seattle, Washington

AFI collaborated with ACF Region X and the Federal Reserve Bank of San Francisco to sponsor an outreach workshop for prospective grantees May 4–5, 2010, in Seattle, Washington. The workshop offered participants information about AFI, including application requirements and procedures, tips for developing strong applications that address the unique needs of Northwest communities, information regarding how culturally sensitive IDA programs can be developed for tribal communities, information regarding forming strong partnerships with financial institutions and developing resources. The event included two special breakout sessions geared for tribal governments and organizations serving Native American communities. Fifteen participants attended the Tribal Breakout Session panels.

AFI Conference – Breakout Session, Asset Building in Native Communities

AFI Program hosted an educational forum on Asset Building in Native Communities at the AFI grantee conference in Washington, D.C., on Tuesday, July 27, 2010. The breakout session featured effective practices, strategies, and information for AFI grantees and organizations interested in learning about serving Native American

communities and partnering with Tribes and Native American organizations. Current AFI grantees and research experts shared success stories, innovative solutions to common challenges, and resources available to organizations serving Native American communities.

Office of Family Assistance (OFA) - Temporary Assistance for Needy Families (TANF)

Region V: continued communication with the executive staff of a Tribe operating a Tribal TANF program during the period of the Tribal TANF program director's illness, leave of absence, and subsequent replacement. Several policy clearances were provided to the case manager during this period.

Regions V and VII TANF held a Bi-Regional Tribal Technical Assistance Workshop. Tribal TANF staff from Regions V and VII conducted a bi-regional event focused on job creation, case management, and domestic violence prevention and treatment at Mystic Lake, Minnesota, August 11-12, 2010. Approximately 26 people from 11 Tribes attended the workshop. The goals of the workshop were to: 1) address the needs of Tribal TANF grantees to identify sources of employment, including the creation of subsidized employment programs; and 2) provide participants with practical information on effective case management, especially for the hard-to-serve and domestic violence survivors.

Regions V and VII TANF conducted a Bi-Regional TANF Emergency Fund Conference Call. Tribal TANF staff from Regions V and VII conducted a special conference call with representatives from their 11 Tribal TANF programs eligible for TANF Emergency Funds on March 3, 2010, and focused on the three categories for awards, as well as application procedures. TANF Emergency Fund awards through September 30, 2010, were $146,362 for the one eligible Region VII Tribe and $441,702 for three eligible Region V Tribes.

Region VI and VIII: Multi-Regional Tribal TANF Conference. OFA, in partnership with the Regions VI and VIII, convened a series of Tribal Roundtable events to help address and capitalize on specific issues identified by Tribes throughout the country. Attended by staff from 16 different tribal governments, the Roundtable series took place April 12-15, 2010, in Denver, Colorado, and featured three major sessions: *Identifying Opportunities for Economic Development In Indian Country Roundtable; ACF Regions VI and VIII Tribal TANF Administrators Meeting;,* and *Identifying and Implementing Effective Case Management Strategies Workshop*. With assistance from Federal and Regional staff and nationally recognized content experts and practitioners, Roundtable participants focused on a number of issues critical to the success and continued sustainability of their TANF programs.

Regions VI and VIII also conducted a separate Tribal TANF administrators meeting on April 13, 2010, focused on providing guidance and technical assistance on the topics of ARRA, fiscal management, and fiscal reporting requirements, and the Tribes were encouraged to share promising practices and issues. There was also representation at the Region VI and VIII meeting from other Tribes in attendance at the Tribal Roundtables and they were encouraged to ask questions and participate.

Region VIII: Region VIII Tribal Technical Assistance. TANF staff hosted three conference calls for Region VIII Tribal TANF administrators currently operating a Tribal TANF program. The calls were held in November, 2009, February, 2010, and August, 2010.

Region VIII Program Networking. The Regional TANF and Child Support Enforcement (CSE) staff has been requested on several occasions by individual Tribes to participate in conference calls between Tribal TANF and Tribal CSE program staff to answer questions and facilitate discussion.

Region IX: Region IX, San Francisco Regional Office provided detailed Tribal TANF related technical assistance and training, including guidance on plan renewals, program development, and regulatory compliance to all 21 Tribal TANF grantees in Region IX, via regular telephone and e-mail contacts, general outreach, etc. Additional technical assistance and training was also provided during individual meetings at the Regional Office with Fort Bidwell Indian Community, Graton Rancheria, Hoopa Valley Tribe, Manchester Point Arena Rancheria, Owens Valley Career Development Center, Pinoleville Tribe, Redwood Valley Rancheria, Scotts Valley Tribe, Shingle Springs Tribe, Soboba Tribe, Smith River Rancheria, and Torres Martinez Tribe.

Region IX provided extensive guidance to the Shingle Springs Tribe in the process of their withdrawal from an existing Tribal TANF program and the development and approval of Shingle Springs' own Tribal TANF program. The Region also worked closely with the Hoopa Valley Tribe, Pascua Yaqui Tribe, and Robinson Rancheria to assist them in qualifying for/meeting the requirements of the TANF Emergency Contingency Fund under ARRA, and worked closely with the Hoopa Valley Tribe, Soboba Tribe, and Morongo Tribe in the development and review of their Tribal TANF renewal plans.

Region IX organized and facilitated a successful informational and strategic development meeting for the following Tribes who share Mendocino County as a nearby reservation service area designation to help avoid conflict over territorial service area rights among the Tribes: **Coyote Valley Reservation, Guidiville Indian Rancheria, Hopland Band of Pomo Indians, Laytonville Rancheria,** Manchester Point Arena Rancheria, Pinoleville Tribe, Redwood Valley Rancheria, Round Valley Indian Tribes, **Scotts Valley Tribe, Sherwood Valley Rancheria.**

Region IX conducted on-site technical assistance and monitoring oversight at the Salt River Pima-Maricopa Indian Community, Scotts Valley Tribe, Southern California Tribal Chairmen's Association, White Mountain Apache Tribe, and Washoe Tribe.

Region IX developed and hosted three separate Rapid Response Technical Assistance workshops for Region IX Tribes. The workshops focused on program and fiscal issues and challenges that had been identified through tribal input and ongoing communication/site visits with the tribal grantees and addressing issues concerning allowable TANF activities and expenditures:

- A 3-day workshop in San Francisco on October 19-21, 2009, with approximately 80 participants from 19 Tribal TANF grantees from throughout Region IX for all Region IX Tribal TANF grantees.
- A 2-day workshop in Scottsdale, Arizona, on September 1-2, 2010, focused the issues of particular concern to the six Arizona Tribal TANF grantees, with 23 participants from the Tribes as well as the State of Arizona.
- A 2-day workshop in San Francisco on August 18-19, 2010, focused exclusively on issues of concern to California/Nevada Tribes, with approximately 50 participants from 12 Tribes.

Region X: Annual Regional Tribal TANF Conference was held Sept 27-29, 2010, in Tulalip, Washington. It was attended by 21 of the 23 Tribal TANF programs in Region X and three Tribes that have expressed interest in pursuing Tribal TANF. The agenda covered ACF initiatives, collaborating with other HHS programs, and other ACF programs.

The Tribal Coalition, an ACF-wide team of the tribal related programs, meets monthly to discuss issues and related activities. The team provides oversight and opportunities where the different teams can collaborate.

Region X TANF staff provided technical assistance to grantees in preparing and submitting Tribal TANF and NEW plan renewal materials by required deadlines. Nine Tribal TANF plans and 11 NEW plans were renewed during 2010.

Region X is taking an active role in helping Tribes to be up to date on reporting. Each Tribe has their own unique approach to fiscal reporting. This makes it challenging.

Region X TANF program staff hosted a conference call for all Region X Tribal TANF grantees regarding TANF Emergency Fund subsidized employment opportunities. The call included an opportunity for grantees to learn from others with successfully implemented subsidized employment programs.

Region X held the Annual Tribal TANF Conference on September 27-29, 2010, at Tulalip Resort, Tulalip, Washington.

- 21 Tribal TANF Tribes attended, plus three non-TANF Tribes. Attendance was 120 in total.
- Tribal attendees spoke on tribal best practices, and Federal staff also spoke at the meeting.
- A Domestic Violence Presentation was presented in response to the ACF Initiative. Two best practices presented on their programs: Lower Elwha, Washington, and Coeur d'Alene, Idaho.
- An Inner Departmental Presentation was presented on Medicaid and its relationship to TANF.
- A Subsidized Employment Presentation was presented.
- Other ACF Programs which provided presentations were Child Support Enforcement, Emergency Preparedness, and Grants Management.

Idaho Quarterly Meetings

- Region X attended the December 2009 meeting in Boise, Idaho, and the July 2010 meeting at the Coeur d'Alene Resort, Idaho.
- Region X partnered with Child Support to attend the December meeting. They partnered with both Child Support and Child Care in the July meeting.
- Each Federal program presented at the meeting.
- Several State programs attended each meeting. Child Support, Child Care, Finance, Child Welfare were at both meetings for the State.

Office of Head Start (OHS)

In FY 2010, the OHS funded 149 Head Start grants totaling $167,480,777, and 41 Early Head Start (EHS) grants totaling $28,579,568. In addition to base funding, AI/AN Head Start grantees

received a total of $2,614,780 in direct T/TA funds and AI/AN EHS grantees received a total of $707,710 in direct T/TA funds. Approximately 8 percent of Head Start and 10 percent of Early Head Start grants were made to grantees in Alaska.

Training and Technical Assistance

In addition to awarding $3,322,490 in direct T/TA grant funds to AI/AN Head Start and Early Head Start grantees, the OHS redesigned its national T/TA system. The national T/TA redesign established a new T/TA Network composed of: (1) National Centers under which 'best practices' will be communicated and content-rich resources and information made available to all grantees including AI/AN grantees; (2) AI/AN, Migrant and Seasonal (MSHS), and State T/TA Centers reconfigured in order to more effectively identify and respond to grantee needs for T/TA; and (3) direct funding to AI/AN and other Head Start programs to implement their own Head Start agency determined T/TA plans.

The AI/AN, MSHS, and State T/TA Centers include two categories of specialists, Early Childhood Education (ECE) Specialists and Grantee Specialists

The AI/AN ECE Specialists will support local AI/AN programs in their work to develop supportive environments for infants, toddlers, and their families, and to improve school readiness outcomes for AI/AN children. AI/AN Grantee Specialists will be deployed to work with AI/AN grantees with needs identified through monitoring, Program Information Reports (PIR), risk management meetings, or other data reviewed by OHS. In FY 2010, the AI/AN T/TA Center conducted cluster trainings on such topics as Classroom Assessment Scoring System (CLASS), fiscal management, nutrition including obesity prevention, community assessments, recordkeeping systems, disabilities services, and planning. In addition to the approximately two weekly calls for each assigned AI/AN Head Start grantee, T/TA Specialists conducted a total of 214 on-site visits to grantees between January 2010 and June 2010.

Head Start Roadmap to Excellence

On January 13, 2010, the OHS launched the "Improving School Readiness and Promoting Long-Term Success: The Head Start Roadmap to Excellence" as part of an Administration-wide effort to close achievement gaps and promote early learning through the first 8 years of life for the nation's most vulnerable children including AI/AN children. Informed by input and recommendations made through tribal consultations and other avenues of communication, OHS will implement the Head Start Roadmap to Excellence in a manner that is responsive to the needs and challenges of AI/AN grantees and fully integrates AI/AN Head Start into the continuum of high-quality early care and education across the United States.

Family Literacy and Engagement

Numerous trainings and resources were provided to AI/AN Head Start grantees by the National Head Start Family Literacy Center (NHSFLC). These included dissemination to all AI/AN Head Start grantees the Training, Information, and Practical Strategies (TIPS) newsletter and the "Getting Ready for School" materials, a set of research-based materials including a training guide, parent guides, handouts, and a children's activity book, that support families to promote their children's school readiness in culturally comfortable ways, using experiences that arise in daily life.

In addition to the above, the Confederated Tribes of Grand Ronde, the Mississippi Band of Choctaw Indians, Pueblo of Laguna, Redding Rancheria, the Yakama Nation, the Sisseton Wahpeton Oyate, the Suquamish Tribe, and the Pueblo of Isleta Head Start

programs participated in a 4-year training effort, Strengthening Partnerships and Resources in Communities for Literacy (SPARC). This training effort included development and modeling of promising practices related to parents as first teachers, interactive literacy activities between parents and their children, and activities to increase male involvement.

In FY 2010, a total of 55 trainings were offered by the NHSFLC involving 1,722 participants from AI/AN Head Start staff and families on the following modules: Home: Where Learning Begins, Talk to Me! Making the Most of Teachable Moments, Getting Ready for School, Math, Follow the Car: Talk and Play, What is Family Literacy, Strengthening Systems in Head Start to Support Family Literacy, and Talking is Teaching: Using Teacher Talk Strategies.

Joint Risk Management Meetings

During FY 2010, a total of 128 risk management meetings were convened with tribal Head Start grantees approximately 90 days prior to refunding for the purpose of identifying strengths as well as areas of performance that need improvement. Such meetings also provided opportunities for AI/AN grantees, OHS program staff, and grant specialists to collaborate to develop action plans to address areas in need of improvement and to sustain areas of strength.

Head Start Program Regulations

Tribal Head Start consultations continue to inform the development of proposed revisions to the Head Start Program Performance Standards with issues, concerns, suggestions, and challenges rose in such consultations considered and addressed. At the time the Notice of Proposed Rulemaking is published in FY 2011, AI/ANs will have additional opportunities to provide input through notice-and-comment rulemaking.

AMERICAN RECOVERY ACT SPECIFIC TO TRIBES

Office of Child Care (OCC)

Recovery Act Improves Access to Quality, Affordable Care in Tribal Communities

Tribes across the country are investing ARRA funds to address critical health and safety needs, improve access to professional development opportunities for providers, upgrade indoor and outdoor child care environments, and expand access to services for low-income families. Tribes are using the additional funds, and the flexibility inherent in the Child Care and Development Fund (CCDF), to increase income and age eligibility thresholds, decrease parental co-payments, and raise provider reimbursement rates. Most importantly, as this issue illustrates, tribal child care programs are partnering with Head Start and Early Head Start programs, braiding and blending a variety of funding streams, and engaging partners at tribal colleges and universities and State and local agencies.

Tribes Use Recovery Act for Direct Services to Low-income Families

- 93 families of the Yakama Nation in Washington continued to receive child care financial assistance thanks to ARRA funding, enabling 118 parents to stay in the workforce.
- The San Carlos Apache Tribe in Arizona hired four additional staff for its new child care center in the Bylas District of the reservation.
- The Flandreau Santee Sioux Tribe in South Dakota eliminated parent co-payments for families at or below the Federal Poverty Income Guidelines.

Tribes Invest in Child Care Health and Safety

Throughout Indian Country, ARRA funds are making improvements in the health and safety of child care settings.

- A number of Tribes, including the Fort Belknap Community Council in Montana, used ARRA funds to provide CPR/first aid and other basic health and safety training courses to help new providers meet licensing standards.
- In Michigan, the Sault Sainte Marie Tribe of Chippewa Indians purchased safety equipment and training materials to help tribally regulated providers meet health and safety standards, as did the Turtle Mountain Band of Chippewa Indians in North Dakota.
- Several programs invested in playground safety. The Smith River Rancheria in California purchased materials for a subsidized center to improve the quality of its outdoor play area and enhance safety around the play structures. In Oregon, the Confederated Tribes of Grand Ronde Indians upgraded the ground cover used on the playground at its early childhood center; the new pourable, recycled rubber product will improve children's safety while reducing maintenance time and expense.

New Activities and Supplies Brighten Tribal Child Care Programs

Using ARRA funds, Tribes are improving the quality of care and education provided by their child care programs in a number of unique ways. For example:

- The Eastern Shawnee Tribe of Oklahoma developed an afterschool program that educates children about Shawnee history, beading, and Native American dance. Similarly, the Hoopa Valley Tribe in California purchased supplies for cultural activities in its child care classrooms.
- The Pokagon Tribe of Michigan used some of its ARRA funds to purchase playground equipment, as well as new toys and other classroom materials.
- The Shawnee Tribe of Oklahoma invested in several quality activities, including a new initiative that offers providers mini-grants to help them institute a program that increases school-age children's physical activity and teaches the children how to make smarter nutritional choices.

Recovery Funds Help Tribes Raise the Bar on Professional Development

The influx of funds ARRA has helped many Tribes increase staff training and professional development opportunities, which are key indicators of child care quality. Tribes have targeted these training dollars to different program areas.

Some tribal CCDF programs, such as the Bois Forte Reservation Tribal Council in Minnesota, focused on helping child care staff members earn Child Development Associate (CDA) credentials. In 2009, to align the staff qualifications for its co-located child care and Head Start programs, the Suquamish Tribe in Washington mandated that all child care staff would obtain CDAs within 1 year of starting work. The Tribe partnered with Northwest Indian College to make courses available onsite at the early childhood center. To date, the Tribe's ARRA funds have helped 10 child care staff earn CDAs; the remaining six staff members will complete their credentials by the end of 2010.

Other Tribes have focused their professional development efforts on improving the quality and availability of infant and toddler care. The Blackfeet Tribe of Montana used

ARRA funds to support infant and toddler training for 12 child care providers. Child care teachers working for the Oneida Tribe of Indians of Wisconsin began classes needed to obtain the Wisconsin Infant/Toddler Credential. Thirteen staff members of the H'man Shawa Early Childhood Development Center at the Fort McDowell Yavapai Nation in Arizona received training about child development and early learning standards for children birth to 3 years. The center is a newly consolidated program that provides all children comprehensive services based on the Early Head Start performance standards, using funds from tribal CCDF, tribal prekindergarten, and First Things First, Arizona's tobacco tax initiative.

CCDF Highlights

Recovery Act Investments Enhance Child Care in Indian Country

- Two tribal CCDF grantees used ARRA funds to address some of the transportation challenges facing rural native families. The Jamestown S'klallam Tribe in Washington State and the Quapaw Tribe of Oklahoma both purchased buses to help transport children to and from their child care programs.
- In Wisconsin, the Red Cliff Band of Lake Superior Chippewa Indians hired a full-time teacher for a collaborative child care/Early Head Start classroom of children ages 18–36 months.
- The Quechan Indian Tribe of Arizona extended Head Start services to CCDF-eligible children. In November 2009, the Tribe opened a new classroom for 14 3-year-old children who had been on the Head Start waiting list. The classroom, funded and operated through CCDF, was developed to meet Head Start standards.
- The Kenaitze Indian Tribe in Alaska expanded its Early Childhood Center's wraparound child care program to serve children ages 3 to 5. The extended operating hours has improved the continuity of care for Kenaitze preschool children. Care for medically fragile children has been improved as well by eliminating the need to transport medications and medical equipment and streamlining communication among parents and caregivers.
- Nationwide, 259 Tribes and tribal organizations were allocated $40,000,000 in ARRA funds.

Region II: CCDF ARRA funding was used to strengthen the Seneca Nation's Family Child Care program by hiring an Early Childhood Educator to visit the providers' homes. The St. Regis Mohawk Tribe used CCDF ARRA funding to create a developmentally appropriate infant toddler playground.

Office of Family Assistance (OFA) – Temporary Assistance for Needy Families (TANF)

Regions VI and VIII: In providing ongoing technical assistance, Regions VI and VIII held a Bi-Regional Technical Assistance and Training Conference April 12-15, 2010, in Denver, Colorado. Representatives of 17 Tribes from both Regions currently operating (or planning to operate) a Tribal TANF program participated. The conference featured three major sessions: Identifying Opportunities for Economic Development in Indian Country Roundtable; a meeting for the Tribal TANF administrators from Regions VI and VIII; and a workshop on Identifying and Implementing Effective Case Management Strategies. Topics covered during the Roundtable Series included job creation, green technologies and their application in Indian Country; ARRA program categories and funding; and case management strategies that empower and motivate TANF participants and staff, with presentations by tribal managers. Subsequently, a conference call was held to provide

requested technical assistance on ARRA TANF Emergency funding for one Region VI Tribe.

Office of Head Start (OHS)

Of the 41 Early Head Start (EHS) grants, 23 were expansion grants under ARRA of which 16 were awards to grantees that operated Head Start programs and demonstrated the community need for services for pregnant women and infants and toddlers. In addition to EHS expansion, $9,152,489 in ARRA funds were awarded in one-time grants for health and safety and other high priority needs such as child safety restraints, roof replacement, replacement of buses, and renovation of facilities cited for health and safety noncompliance.

AFFORDABLE CARE ACT ACTIVITIES SPECIFIC TO TRIBES

Administration on Children, Youth, and Families – Families and Youth Services Bureau
Personal Responsibility Education Program (PREP) – Teen Pregnancy Prevention

As part of Health Care Reform, FYSB acquired the PREP and within this program is a tribal set-aside of 5 percent, or $3.25 million in discretionary grants. The program has been authorized from 2010 to 2014. The legislation required tribal consultation prior to the development of Tribal PREP, and FYSB conducted four in-person consultation sessions as well as four national conference calls.

TRIBAL DELEGATIONS MEETINGS

Administration on Children, Youth, and Families (ACYF)- Children's Bureau (CB)
Region II:

- Region II participated and presented in two tribal consultations with Region II Tribes that were hosted by the New York State Office of Children and Family Services.
- In the first tribal consultation, Region II welcomed the Shinnecock Nation as the most recent Federally-recognized Tribe in the Region.
- Identified potential issues/allegations of violations under the Indian Child Welfare Act through the tribal consultations that will require on-going Federal, State and tribal discussions.

Office of Child Support Enforcement (OCSE)

Region VI presented an overview of tribal child support to participants at the Texas Tribal/State Relations Workgroup. The Workgroup is comprised of representatives of the Alabama Coushatta Tribe of Texas, the Kickapoo Tribe of Texas, and the Ysleta Del Sur Pueblo, as well as human services agencies in the state of Texas. Region VI participation in this event also served to follow-up with representatives of the Ysleta Del Sur Pueblo who had expressed interest in developing a tribal child support program while in attendance at the ACF Tribal Consultation. The presentation on tribal child support was well received resulting in requested technical assistance to develop a tribal child support start-up application by the Alabama Coushatta Tribe of Texas.

Region VI joined the HHS/Region VI regional director and representatives from other HHS agencies in participating in the pre-consultation Region VI meeting. Approximately 120 representatives from Tribes and tribal organizations within Region VI attended the informal session which delivered technical assistance on tribal child support and provided a “point of contact” for future problem solving for the child support community.

Region VI participated in the HHS Region VI and VII tribal consultation held at the Pueblo Indian Cultural Center in Albuquerque, New Mexico. The purpose of the meeting was to provide an opportunity for tribal leaders and their representatives in the two regions to engage in detailed discussions with HHS. Specifically, over 150 participants provided testimony and commented on issues related to HHS' tribal policies, processes, and advisory committees. Region VI served as resource and subject matter experts on the tribal child support enforcement program.

Region VI has been an active member and sponsor of the New Mexico Tribal-State Judicial Consortium since 2001. In 2003, the Region VI tribal child support team was instrumental in the expansion of the Consortium's mission statement to include child support. The Consortium was formed to strengthen relationships and communications between tribal and State judiciary within the geographic boundaries of New Mexico. Region VI serves as resource and subject matter experts on child support to the Consortium and participate in meetings and conferences as appropriate.

Region IX: Region IX has been working with the Navajo Nation child support program (NN) over the past year to provide assistance and training, including identifying areas in which the NN program is interested in improving and potential sources of assistance (e.g., other tribal programs), arranging training and assistance from the Arizona child support program on the automated system used by NN offices located in Arizona, regional staff presenting at the NN annual training conference, and making sure they are aware of other training opportunities. Region IX has also worked closely with Navajo Nation leadership during a period of management transition to assure program continuity and to open communications, including arranging a meeting for the Navajo Nation leadership with the OCSE Commissioner at Western Interstate Child Support Enforcement Conference.

Region IX has also worked with the Yurok Tribe in California regarding their interest in operating a title IV-D tribal child support program, including reviewing and commenting on a draft application for start-up funding.

Office of Community Services (OCS)

OCS's Division of State Assistance – Meeting with Navajo Nation.

Seth Hassett, Division of State Assistance (DSA) Director and a DSA Program Specialist met with the Navajo Nation Tribe on Friday, March 5, 2010, to discuss questions the Tribe presented regarding CSBG and Social Services Block Grant (SSBG) funding. The meeting created an opportunity for DSA staff and the grantee to meet in-person, and for DSA to communicate their devotion to building relationships with tribal grantees.

Office of Family Assistance (OFA) – Temporary Assistance for Needy Families (TANF)

OFA/TANF staff met with a delegation of the Lac Courte Oreilles Band of Ojibwe, including the tribal chairman and members of the Tribal Governing Board, in Prior Lake, Minnesota, on August 11, 2010, to discuss the Tribe's plans to become a Tribal TANF grantee. The meeting was also attended by the State of Wisconsin Department of Children and Families' Tribal Liaison.

Office of Head Start (OHS)

The OHS scheduled eight tribal consultation sessions for the purpose of better meeting the needs of Native American and Alaska Native children and their families, in accordance with Head Start program requirements and authorities, taking into

consideration funding allocations, distribution formulas, and other issues affecting the delivery of Head Start services in their geographic locations. These consultations were undertaken with a commitment to meaningful consultation with Tribes through which elected officials and other authorized representatives of the tribal governments had opportunities to provide meaningful and timely input prior to the development of policies, the development of new performance standards, and other policies or procedures that affect Tribal Head Start grantees.

On June 16, 2010; June 29, 2010; July 15, 2010; July 30, 2010; August 16, 2010; August 27, 2010; October 18, 2010; and October 20. 2010; the OHS tribal consultation sessions were scheduled in San Diego, California; Rock Hill, South Carolina; Green Bay, Wisconsin; Tulsa, Oklahoma; Boston, Massachusetts; Rapid City, South Dakota; Auburn, Washington; and Fairbanks, Alaska; respectively. Among the issues raised in the consultation sessions were (1) teacher qualifications and retention; (2) non-Federal match requirements; (3) treatment of indirect costs; (4) facility needs; (5) enrollment challenges; (6) communications among AI/ANs and the OHS, as well as Office of Grants Management staff; and (7) language and culture preservation. While some of the specific recommendations made in the course of OHS tribal consultations require legislative action, other recommendations have informed the development of Head Start priorities and action plans. The OHS participated in the 1st ACF Tribal Consultation Session convened in Washington D.C.

TRIBAL DELEGATIONS MEETINGS

Administration for Native Americans (ANA)

ANA facilitates the ACF's internal Native Affairs Workgroup. This workgroup met regularly throughout the year to discuss collaborative opportunities for tribal programs.

Office of Family Assistance (OFA) – Temporary Assistance for Needy Families (TANF)

In providing ongoing technical assistance, Regions VI and VIII held a Bi-Regional Technical Assistance and Training Conference on April 12-15, 2010, in Denver, Colorado. Representatives of 17 Tribes from both Regions currently operating (or planning to operate) a Tribal TANF program participated. The conference featured three major sessions: Identifying Opportunities for Economic Development in Indian Country Roundtable; a meeting for the Tribal TANF administrators from Regions VI and VIII; and a workshop on Identifying and Implementing Effective Case Management Strategies. Topics covered during the Roundtable Series included job creation; green technologies and their application in Indian Country; ARRA program categories and funding; and case management strategies that empower and motivate TANF participants and staff, with presentations by tribal managers. Subsequently, a conference call was held to provide requested technical assistance on ARRA TANF Emergency funding for one Region VI Tribe. OFA/Division of Tribal TANF Management participated in the 2010 HHS Tribal Budget Consultation.

AGENCY TRIBAL CONSULTATION POLICY

In 2010, ACF began drafting a Tribal Consultation Policy. This policy was developed in conjunction with an ACF Tribal/Federal Policy Workgroup and was presented at the ACF Tribal Consultation meeting held September 29, 2010. ACF plans on issuing a final policy document in early 2011. Until such time as a final policy has been issued, ACF has agreed to follow the Secretary's Tribal Consultation Policy

United States Department of Health and Human Services

Administration on Aging (AoA)

The Administration on Aging (AoA), an agency in the U.S. Department of Health and Human Services, is one of the nation's largest providers of home- and community-based care for older persons and their caregivers. Our mission is to develop a comprehensive, coordinated and cost-effective system of long-term care that helps elderly individuals to maintain their dignity in their homes and communities. Our mission statement also is to help society prepare for an aging population.

Created in 1965 with the passage of the Older Americans Act (OAA), AoA is part of a Federal, State, Tribal and local partnership called the National Network on Aging. This network, serving about 7 million older persons and their caregivers, consists of 56 State Units on Aging; 655 Area Agencies on Aging; 244 Tribal organizations; two organizations that serve Native Hawaiians; 29,000 service providers; and thousands of volunteers. These organizations provide assistance and services to older individuals and their families in urban, suburban, and rural areas throughout the United States. While all older Americans may receive services, the OAA targets those older individuals who are in greatest economic and social need: the poor, the isolated, and those elders disadvantaged by social or health disparities.

The Office for American Indian, Alaskan Native, and Native Hawaiian Aging was established in the Older Americans Act under Title II, Section 201. The Director of the Office has several responsibilities to include serving as the effective and visible advocate in behalf of older individuals who are Native Americans within the Department of Health and Human Services and with other departments and agencies of the Federal Government regarding all Federal policies affecting such individuals and administering and evaluating the grants provided under this Act to Indian tribes, public agencies and nonprofit private organizations serving Native Hawaiians.

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HIGHLIGHTS OF DIVISION SPECIFIC ACCOMPLISHMENTS/ACTIVITIES TARGETED TOWARD AMERICAN INDIANS/ALASKA NATIVES (AI/AN)

Nutrition and Supportive Services Grants to 244 Indian Tribal Organizations

On March 30, 2010, AoA awarded $26,439,461 to Indian Tribal Organizations for nutrition and supportive services, including transportation, homemaker and chore services, in order to help elders remain independent in their homes and communities. Congregate Nutrition Services provided more than 2 million meals to more than 49,000 Native American elders in community settings, providing an opportunity for older adults to socialize and participate in a variety of activities including cultural and wellness programs. Home-Delivered Nutrition Services provided more than 2.3 million meals to almost 21,000 homebound Native American elders, as well as critical social contacts that help reduce the risk of depression and isolation experienced by many homebound elders. Transportation services provided approximately 933,000 rides to meal sites, medical appointments, grocery stores, and other critical daily activity locations.

Native American Caregiver Support Grants to 203 Indian Tribal Organizations

On March 30, 2010, AoA awarded $6,315,547 to Indian Tribal Organizations to help them support unpaid family members in caring for their elders and grandparents raising their grandchildren by providing training on care giving, caregiver support groups, and respite. Nearly 34,000 units of in-home services helped Native American caregivers. Approximately 994,000 hours of outreach and information services empowered Native American elders and their families to make informed decisions about their care needs. More than 30,000 units of counseling and support group services helped caregivers caring for older adults and approximately 71,000 units of respite services were provided to caregivers caring for older adults or grandparents caring for their grandchildren.

American Recovery and Reinvestment Act

On April 2, 2009, AoA awarded $3 million dollars to Indian Tribal Organizations allowing AoA Title VI programs to expand services, hire personnel and keep some programs from closing when other funds were expended. There have been 41,934 elders served by the ARRA grants and a total of 900,572 meals provided with ARRA funds.

Nutrition Service Incentive Grants to 242 Indian Tribal Organizations

On April 10, 2010, AoA awarded $3,188,097 to Indian Tribal Organizations to support their congregate and home delivered meals program.

MIPPA Grants to 177 Indian Tribal Organizations

On September 27, 2010, AoA awarded $1 million dollars from the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) to Indian Tribal Organizations to allow Older Americans Act Title VI programs to help eligible Tribal members understand the Low Income Subsidy program, Medicare Savings Program, and Medicare Part D.

REGIONAL VISITS TO TRIBES

Assistant Secretary for Aging, ***Kathy Greenlee***, convened three national Listening Sessions to receive input for the 2011 reauthorization of the Older Americans Act. Tribal delegates were invited at each of the Listening Sessions and other Tribal representatives provided testimony. Testimony was recorded/ incorporated into the AoA/Reauthorization Listening Session Report.

TRIBAL SUMMITS

The National Title VI Training Forum was held in Denver, Colorado from August 3 to 5, 2010. Nearly 250 Tribal Council members, Tribal Senior Program Directors and Tribal staff attended the Forum. Deputy Assistant Secretary for Aging, Cindy Padilla, convened a Tribal Listening Session in conjunction with the National Forum.

The Conference objectives were to strengthen AoA's Title VI programs, to ensure our renewed commitment to quality services for older American Indians, Alaska Natives and Native Hawaiians, to provide training on current program guidelines, and to strengthen our partnerships with the Tribes and with other Federal agencies providing services to Tribal organizations. Region VIII Director, Marguerite Salazar welcomed the group and also spoke of the renewed commitment to Tribal relations and collaboration. She outlined the President's Executive Order and her Region's commitment to Tribal Consolation, Regional Consultation, and Agency consultation.

It was noted that through the reauthorization of the Indian Health Care Improvement Act as part of the passage of the Affordable Care Act, AoA intends to strengthen its partnership with Indian Health Services to support and coordinate Long Term Care in Indian Country.

Comments at the Listening Session included: a need for increased funding; better coordination between Titles III and VI; better laws to support the prevention of elder abuse; and more collaboration to provide more transportation options on reservations.

United States Department of Health and Human Services

Agency for Healthcare Research and Quality (AHRQ)

As 1 of 12 agencies within the Department of Health and Human Services, the Agency for Healthcare Research and Quality (AHRQ) supports health services research initiatives that seek to improve the quality of health care in America. AHRQ's mission is to improve the quality, safety, efficiency, effectiveness, and cost-effectiveness of health care for all Americans. The Agency works to fulfill this mission by conducting and supporting health services research, both within AHRQ as well as in leading academic institutions, hospitals, physicians' offices, health care systems, and many other settings across the country. The Agency has a broad research portfolio that touches on nearly every aspect of health care.

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Tribal Consultation Policy: Yes

HIGHLIGHTS OF DIVISION SPECIFIC ACCOMPLISHMENTS/ACTIVITIES TARGETED TOWARD AMERICAN INDIANS/ALASKA NATIVES (AI/AN)

In FY 2010, AHRQ funded five grants (new or continued funding) that specifically focus on American Indian/Alaska Native populations; one is funded with money from the American Recovery and Reinvestment Act (ARRA). Also, AHRQ is working closely with the Indian Health Service (IHS) on two comparative effectiveness research projects supported with the Office of the Secretary's (OS') ARRA funds. These efforts are being led out of one of AHRQ's research centers and is headed by an IHS staff person on detail to AHRQ.

DIVISION SPECIFIC ACTIVITIES

AHRQ supports a research infrastructure development project run by the Montana-Wyoming Tribal Leaders Council which includes six studies addressing in-depth topics. (#14034)

Summary: This continuation grant builds upon an earlier capacity-building grant during which the Montana-Wyoming Tribal Leaders Council developed a shared data resource and research infrastructure for participatory research among a majority of the 10 tribes it serves. The continuation project will further build capacity for health care research on the priority health issues identified by the tribes and continue to support culturally appropriate health programs. Funded projects include ones on seat belt use, eye disease, suicide prevention, emergency medical services, and physical and mental health care access improvement.

AHRQ supports a research project to assess AIs/ANs perceptions of their care. (#16978)

Summary: Yale researchers together with the Eastern Shoshone and Northern Arapaho Tribes of the Wind River Indian Reservation and the Fort Peck Indian Reservation Tribes (Assiniboine and Sioux) in Montana are collaborating on two quality improvement projects. At Wind River, the Tribal Health Directors and the IHS leadership team are collecting baseline Health Plan CAHPS® Survey data to identify patients' perceptions of the care they received. Results are to be reported to the Tribal-IHS Working Group. At the Fort Peck Indian Reservation, the Yale team is working with the Tribal Health Director to collect baseline patient experience data in the Tribally-operated dialysis unit with the CAHPS® In-Center Hemodialysis Survey. After review of the data, quality improvement interventions will be developed.

AHRQ supports a research project that addresses the effects of a patient-centered medical home model on quality, safety, efficiency, effectiveness and cost for an urban AI/AN population. The work proposed is relevant to other practices serving diverse populations with multiple health disparities. (#19154)

Summary: The Southcentral Foundation (SCF) in Alaska, a tribally-owned organization, assumed management of primary care service in 1998 for AI/ANs in the Anchorage area. SCF implemented a patient-centered medical home (PCMH) model in 1999 and 2000. The SCF PCMH model has three key characteristics: patient-selected family match to a primary care team, patient-driven care, and advanced access. The SCF PCMH is viewed as a success within quality improvement circles but the impact of the PCMH transformation has not undergone rigorous scientific investigation. In this effort, University of Alaska Anchorage and SCF are partnering to address the following specific aims: 1) to determine the impact of the PCMH transformation on the characteristics and quality of patient care delivery and 2) to assess changes in healthcare delivery, such as quality and safety efforts, efforts to bring evidence to the point of care, use of information systems, and costs. To date, there have been no studies which examine the impact of a

health system redesign among the AI/AN population. As the PCMH model lends itself to implementation in other primary care settings, this effort could have national implications for improving the health status of AI/AN people.

AHRQ supports a research project focusing on the improvement of stroke care. (#17956)

Summary: The goal of this study is to improve the quality of stroke rehabilitation care in an underserved community of eastern North Carolina. The study seeks to implement an innovative, multi-disciplinary, specialty-care intervention that targets early introduction to rehabilitation and assists with transitions between levels of care received during the rehabilitation process. This is a two-phase project. In Phase I, the researchers will observe the current stroke rehabilitation process of care, and in Phase II, they will improve the process and increase access to stroke specialty care by providing a multi-disciplinary consultation service using telemedicine. This approach will increase early introduction to rehabilitation and maximize physical activity, a measure of secondary prevention. The project addresses quality issues of timeliness, effectiveness, and patient-centered care. It will take place at Southeastern Regional Medical Center, a rural community hospital that serves a poor, tri-racial population (25% African American, 38% Lumbee Indian, and 33% white).

AMERICAN RECOVERY ACT SPECIFIC TO TRIBES

Using ARRA funds, AHRQ supports a research project aimed at correcting race information in public health data sources to allow accurate assessment of health status among American Indians and Alaska Natives in a 3-State Northwestern U.S. area. (#19972)

Summary: Correctly assessing the health status of American Indians/Alaska Natives (AI/AN) and other minority populations is complicated by the fact that public health data sources often fail to capture accurate race information. Using the most complete roster of Northwest AIs/ANs available, the Improving Data & Enhancing Access-Northwest (IDEA-NW) Project will complete probabilistic record linkages with external datasets in a three-state region to identify and correct inaccurate race data for AI/ANs. Repeating these linkages at regular intervals will allow for an evaluation of the extent of racial misclassification in these data systems over time, and provide measures of the project's success in mitigating errors. The result will be more accurate rates and trends in specific health conditions affecting Northwest AIs/ANs, informing local and regional efforts to eliminate health disparities.

AHRQ is continuing its efforts to work with IHS on several fronts including two large ARRA programs funded with OS ARRA funds:

Summary: One project will use electronic clinical data from the IHS national health information systems to create a longitudinal database linking quality of care measures for diabetes, cardiovascular disease, and cancer screening over a 9-year period. A second objective will be to conduct two comparative analyses to determine the effectiveness of delivery system interventions, such as the use of an advanced electronic health record and a chronic care model to assess health care quality and outcomes for diabetes, cardiovascular care, and cancer screening. AHRQ is providing staff support to IHS in this project with OS ARRA funding.

Summary: Another comparative effectiveness study will compare disease management by advance practice pharmacists with other health care providers within the IHS. Pharmaceutical care and the expanded role of pharmacists have been associated with many positive diabetes-related outcomes, including improved clinical measures,

improved patient and provider satisfaction, and improved cost management. Within the IHS, 22 percent of pharmacists are advance practice pharmacists who are nationally credentialed and locally privileged to provide prescriptive pharmacy care and clinical monitoring for acute and chronic disease management. AHRQ is providing staff support to IHS in this project supported with OS ARRA funding.

TRIBAL DELEGATIONS MEETINGS

Tribal Summits/Workgroups/Task Force Meetings

AHRQ actively participated in the annual Tribal Budget Summit that took place in the spring of 2010 in Washington, D.C. AHRQ was represented by its Director, Dr. Carolyn Clancy. The Budget Summit is organized by the Office of Intergovernmental Affairs, HHS.

AHRQ is actively involved in the Department-wide Intradepartmental Council on Native American Affairs (ICNAA).

Agency Tribal Technical Advisory Group

AHRQ is actively involved in the work of the AI/AN Health Research Advisory Council which provides input to the Department on health research matters. Given its small size and limited budget, AHRQ does not have a technical advisory group of its own.

United States Department of Health and Human Services

Assistant Secretary for Preparedness and Response (ASPR)

The Office of the Assistant Secretary for Preparedness and Response (formerly the Office of Public Health Emergency Preparedness) serves as the Secretary's principal advisory staff on matters related to bioterrorism and other public health emergencies. ASPR also coordinates interagency activities between HHS, other Federal departments, agencies, and offices, and State and local officials responsible for emergency preparedness and the protection of the civilian population from acts of bioterrorism and other public health emergencies.

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HIGHLIGHTS OF DIVISION SPECIFIC ACCOMPLISHMENTS/ACTIVITIES TARGETED TOWARD AMERICAN INDIANS/ALASKA NATIVES (AI/AN)

ASPR Hosted End-User Roundtable on Emergency Medical Countermeasures

Tribal public health emergency response and/or planning officials from the Southern Ute, Shoshone, and Arapaho were invited to participate in the Chemical, Biological, Radiological, and Nuclear (CBRN) Medical Countermeasure End-User Roundtable in Denver, Colorado in November of 2009.

2009 H1N1 Influenza Response Review

Through ASPR and in partnership with IGA, IHS, and our regional offices, approximately 200 Tribal Nation and coalition representatives were invited to participate in the webinars, meetings, and dialog sessions hosted by HHS in 2010 to obtain input for the H1N1 Retrospective, a comprehensive review of the response to 2009 H1N1 Influenza.

ASPR Hosted Roundtable on the National Health Security Strategy (NHSS), Bethesda, Maryland, October 26-27, 2010

The ASPR Division for At-Risk Individuals, Behavioral Health, and Community Resilience hosted a workshop to discuss NHSS Biennial Implementation Plan strategies

and measures related to behavioral health, at-risk individuals, and community resilience. Several Tribal Nations were invited and the Deputy Director of Health and Human Services for Ysleta del Sur Pueblo was in attendance.

ASPR HPP Funds Available to Tribal Healthcare Facilities

Tribal healthcare facilities are eligible to receive funding through awardees of the Hospital Preparedness Program (HPP) Cooperative Agreement. The most recent FY10 HPP funding was awarded to State and Territorial Departments of Public Health on July 1, 2010. Additional information about HPP can be found under the Catalog of Federal Domestic Assistance (CFDA) Number 93.889.

ASPR EWIDS Funds Available to Tribes for Epidemiology-Related Activities

Since Fiscal Year 2003, HHS/ASPR has made available approximately $38.7 million to the 20 U.S. Border States along the northern and southern international borders with Canada and Mexico as a supplement for Early Warning Infectious Disease Surveillance (EWIDS) via the Centers for Disease Control and Prevention (CDC) Public Health Emergency Preparedness (PHEP) Cooperative Agreement program. EWIDS funds are intended strictly for the support of cross-border surveillance and epidemiology-related activities to address bioterrorism and other infectious disease outbreaks with the potential for catastrophic consequences (including pandemic influenza).

In general, HHS explicitly requires all jurisdictions to include Indian Tribes in the development, implementation, and evaluation of their bioterrorism work plans. Particularly, under the U.S. Border States EWIDS supplement, resources are provided to the Border States to support and coordinate public health efforts, including those among Tribal jurisdictions straddling the international borders. Resources are used to continue to engage federally-recognized Tribes along the international border in those States for cross-border infectious disease surveillance activities through mutual aid compacts, memoranda of understanding, and/or agreements.

EWIDS guidance to the Border States also encourages, where appropriate, the inclusion of local bi-national health councils and/or Indian Tribes or Native American organizations in bioterrorism surveillance activities. Specifically, border Tribal jurisdictions are eligible to receive EWIDS supplement funding under the PHEP cooperative agreements with the Border States awardees, to jointly participate in all-hazards planning meetings, exchange health alert messages and epidemiological data, provide mutual aid, and conduct collaborative drills and exercises.

United States Department of Health and Human Services

Centers for Disease Control and Prevention (CDC)

The mission of CDC is to promote health and quality of life by preventing and controlling disease, injury, and disability. CDC seeks to accomplish its mission by working with partners throughout the nation and the world to:

- monitor health,
- detect and investigate health problems,
- conduct research to enhance prevention,
- develop and advocate sound public health policies,
- implement prevention strategies,
- promote healthy behaviors,
- foster safe and healthful environments,
- provide leadership and training.

Those functions are the backbone of CDC's mission. Each of CDC's component organizations undertakes these activities in conducting its specific programs. The steps needed to accomplish this mission are also based on scientific excellence, requiring well-trained public health practitioners and leaders dedicated to high standards of quality and ethical practice.

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HIGHLIGHTS OF DIVISION SPECIFIC ACCOMPLISHMENTS/ACTIVITIES TARGETED TOWARD AMERICAN INDIANS/ALASKA NATIVES (AI/AN)

National Indian Health Board (NIHB): Strengthening Existing National Organizations Serving Racial & Ethic Populations (OSTLTS)

The purpose of the Cooperative Agreement between CDC's Office for State, Local, Tribal and Territorial Support and the National Indian Health Board (NIHB) is to improve the health of the underserved American Indians and Alaska Natives (AI/ANs) by strengthening efforts to build public health capacity throughout Indian country and foster culturally appropriate public health care services that focus on partnership building, health advocacy, promotion, education, and prevention. At the center of these public health initiatives is the strong, collaborative relationship between NIHB and CDC, which is vital to successfully achieving critical health outcomes for the American Indian and Alaska native (AI/AN) populations throughout the United States.

Working together since May 2006, NIHB and CDC have been able to provide Tribes with technical assistance with a variety of health issues as well as continuing to promote and engage all parties in the Tribal consultation process with CDC. During FY10, NIHB will be coordinating the evaluation of the program processes, activities, and progress to examine whether goals and objectives have been met and to what extent.

NIHB continues to demonstrate progress towards achieving the long term goals of supporting collaboration between CDC and tribes nationwide, strengthening public health connectivity, identifying and developing culturally appropriate approaches to reduce disease burden, and strengthening AI/AN public health systems capacity. Throughout FY10, NIHB engaged with ASTHO to facilitate more effective working relationships between tribes and states regarding public health activities. They are currently working with NACCHO and ASTHO to explore how the accreditation model developed can be applied in settings to eligible accreditation applicants. NIHB actively participated and provided analytic and policy support for TCAC members for both CDC's Tribal Consultation Advisory Committee (TCAC) meetings, Atlanta, Georgia (January 2010) and Rocky Boy, Montana (July 2010). NIHB through their established infrastructure in area Tribal Health Boards has played a significant role in increasing tribal access to CDC and its resources.

The NIHB agreement provides a venue to increase collaboration among public health partners at national, region, state, tribal and local levels; ensure that AI/AN communities are equally protected from infectious, occupational, environmental and terrorist threats; and influence the public health workforce pipeline to ensure that more Native students enter public health schools and related careers.

Tribal Epi Center Consortium (TECC) (OSTLTS)

The Northwest Tribal Epidemiology Center (NTEC), the Southern Plains Inter-Tribal Epidemiology Center, and the California Tribal Epidemiology Center have established a Tribal Epi Center Consortium (TECC). This interregional network is collaborating to strengthen tribal Epidemiologic and public health capacity and to promote the standardization and culturally component use of health data to improve the health of Native people. The TECC has engaged tribal advisory boards, national and regional organizations serving AI/ANs, academic institutions, and state health departments. TECC implements on-going Public Health Surveys; survey results are utilized to inform on-going health initiatives in each region. TECC is assisting state and federal agencies

to recognize the diversity among individual tribes and regions of Indian country, both in terms of health characteristics of the population and the manner in which health services are delivered. They continue to assist tribes to participate in state federal surveillance activities, utilizing health data to bring about positive changes in health of their communities, and have increased collaboration among Epi Centers in different regions to maximize the expertise and scarce resources that exist to serve the public health needs of the tribes.

Health Research Advisory Council (HRAC) (OSTLTS)

The Office for State, Local, Tribal and Territorial Support provides funding to support Health Research Advisory Council (HRAC) activities of the AI/AN Health Research Group. The purpose of this Inter-Agency Agreement (IAA) is to collaborate with HHS, OMH and other OPDIVs to support research on the health needs of American Indians and Alaska Natives and to gather tribal input on the research needs and priorities of the tribes. Inputs provided by the tribal representatives are used as an important source of information in the developing and coordinating of research portfolios. Principal goals are to establish a group of tribal leaders to provide input on the health research priorities and needs of AI/ANs. The group serves three distinct functions: 1) Obtain input from tribal leaders on health research priorities and needs for their communities; 2) Provides a forum through which Operating Divisions (OPDIV) and Staff Divisions (STAFFDIV) representatives can better communication and coordinate the work their respective organizations are doing in AI/AN health research; and 3) Provide a conduit for disseminating information to tribes about research findings from studies focusing on the health of AI/AN populations.

During HHS 12th Annual National Tribal Budget Formulation and Consultation Session held March 3-4, 2010, HRAC highlighted the following concerns: 1) Continued support for the National Children Study – HRAC proposed a parallel study that directly targeted additional counties and American Indian/Alaska Native (AI/AN) populations, which complements the current NCS sample; 2) Health Disparities – Research should focus on: data quality and accuracy to address under-representation of American Indians and Alaska Natives in population health data, the lack of access to health care services or AI/ANs in both rural and urban settings, lack of incorporation of traditional health care practices and traditional diets, the efficacy of health promotion/disease prevention activities, and lack of health insurance coverage for AI/ANs and; 3) Suicide and Suicide Related Behavior – suicide prevention research needs to be framed to address and understand the issue of suicide from an Indigenous perspective, looking for cultural strengths and commonalities. HRAC will continue to collaborate with CDC, various HHS operating and staff divisions to improve research activities affecting Indian Country.

National Public Health Improvement Initiative (OSTLTS)

The Centers for Disease Control and Prevention is funding 75 state, tribal, local and territorial health departments or their bona fide agents to implement projects totaling $42.5 million to systematically increase their performance management capacity and improve their ability to meet national public health standards. The following 8 tribes were funded: Alaska Native Tribal Health Consortium; Cherokee Nation; Gila River Indian Community Mille Lacs Band of Ojibwe; Montana-Wyoming Tribal Leaders Council; The Navajo Nation Tribal Government; Northwest Portland Area Indian Health Board and SouthEast Alaska Regional Health Consortium

Strategic Alliance for Health (NCCPPHP)

The Cherokee Nation Community Health Promotion Program and the Cherokee County Community of Excellence Tobacco Coalition partnered to successfully promote the adoption of a 24/7 tobacco free ordinance for seven city parks. Both entities promote healthy communities for a healthier Oklahoma and are invested in reducing secondhand smoke through policy change. The partners leveraged resources and engaged stakeholders to conduct outreach and to increase awareness about the health effects of tobacco. The strategy focused on communicating the need for tobacco control policies and explaining how policies help make the healthy choice the easy choice. Youth leaders representing local school-sponsored Students Working Against Tobacco Teams (SWAT) presented the ordinance to the city government and advocated for its adoption. The city council adopted the ordinance in May 2010. The City of Tahlequah is the fourth city in Oklahoma to adopt a policy requiring all city parks and recreation facilities to be tobacco free at all times. The ordinance has the potential to impact the City of Tahlequah residents (16,080 population) and many citizens of Cherokee County (45,000 population).

REACH (NCCPPHP)

The Hannahville Indian community planned and hosted a Native Health Summit in April 2009. The Summit featured Native spiritual leaders, health care providers, and traditional medicinal people sharing wisdom about Native health and wellness, with an emphasis on heart health and diabetes. The Health Summit provided attendees with information on traditional use of tobacco for natives, and speakers discussed the Mind, Body, Spirit connection as it relates to the prevention of chronic disease.

Communities Putting People to Work (CPPW) - (NCCPPHP) Increased Physical Activity

The Cherokee Nation is launching a new community-based campaign, The Cherokee Challenge. It is designed to encourage tribal members to improve their health through improved nutrition, increased physical activity, and decreased commercial tobacco use. As part of the campaign, the Cherokee Nation will sponsor a series of races and walks over the coming months that challenge participants to race with Principal Chief Chad Smith or walk with First Lady Bobbie Smith. “This part of the challenge started when I was asked to be a guest runner in the Tulsa Run. This high-profile event fits with our commitment to be a healthy and happy people,” says Principal Chief Chad Smith. The Cherokee Nation also will offer activities and training tips for everyone who wants to participate. “The initiative works hand in hand with our existing program activities. It is a way for us to encourage people to make good choices relating to their health and have fun working together in reaching that goal,” says Smith.

Tobacco-CPPW (NCCPPHP)

As the program director of the Wisconsin Native American Tobacco Network and a former smoker, Teresa K. Barber has witnessed firsthand how smoking has devastated American Indian communities. “I have seen how smoking exacerbates the conditions of high blood pressure, heart disease, cancer, and chronic obstructive pulmonary disease,” says Barber. The five tribes of the Great Lakes Inter-Tribal Council are determined to slow the negative consequences of tobacco use among their communities. “Commercial tobacco use is a product of historical trauma for American Indians,” says Barber, and therefore, “We see value in using cultural strengths to educate against commercial tobacco use to counter the effects of years of oppression.” Increasing the availability of traditional tobacco, which is used by American Indians for religious and ceremonial purposes, will create communitywide respect for and educate people about its sacred

role. “By educating the community, we are hopeful that the future will be brighter for younger generations,” says Barber.

Nutrition-CPPW (NCCPPHP)

Obesity and diabetes are relatively new problems in the Pueblo of Jemez. With the support of the CPPW initiative and a passionate leadership team, the community is ready to reverse this trend and is committed to developing long-term solutions to obesity. The schools serving Jemez children, the summer recreation program, the Jemez Senior Center, and Community Wellness and Public Health Programs have formed a team to ensure healthy food choices and increased physical activity in all populations of the Pueblo. Families and farmers are encouraged to grow extra vegetables in their gardens for use in schools and the Senior Center and Jemez Pueblo is also encouraging the creation of new community gardens. The community encourages residents to revert “Back to the Old Ways,” a campaign that signifies how past community members ate healthy foods and worked hard in the fields.

Funding to Reduce Tobacco Use Awarded to Tribal Support Centers (NCCDPHP)

The purpose of the Tribal Support Centers program is to reduce commercial tobacco use among American Indian and Alaska Native tribal members; eliminate exposure to secondhand smoke; promote commercial tobacco cessation; and prevent youth initiation of commercial tobacco use. A total of 8 tribal programs successfully competed for funding to implement evidence-based activities that are organized according to MPOWER, a set of policy interventions and strategies to reduce tobacco use, exposure to secondhand smoke and prevent youth initiation. The tribal programs were selected for a 5-year cooperative agreement for an annual total of $1,865,340. As a group, they represent 88 tribal communities with more than 860,000 enrolled members, and are located within 12 states. The funded tribal programs are: Inter-Tribal Council of Michigan; Tanana Chiefs Conference, AK; Southeast Alaska Regional Health Consortium; Nez Pierce Tribe, ID; Muscogee Creek Tribe, OK; Black Hills Center for American Indian; Health – Navajo Nation, AZ; Great Plains Tribal Chairmen, SD and Cherokee Nation, OK

Preventive Health and Health Services (PHHS) Block Grant (NDDCPHP)

The PHHS block grant provides flexible funding to allow states, territories, and tribes to tailor prevention and health promotion programs to their particular public health needs. Two American Indian tribes receive PHHS funding. The Kickapoo Tribe in Kansas uses PHHS funding to increase physical activity among children and youth ages 5-21. It developed an after school program at the Boys & Girls Club to promote physical activity through the use of sports, games, and cultural teachings. The Santee Sioux Indian Tribe in Nebraska uses PHHS grant funding to support the only emergency medical services available to tribe members.

Addressing Motor Vehicle Injuries among American Indians and Alaska Natives through Programs and Research (NCPIC)

NCIPC funded pilot programs from 2004-2009 in four Tribal communities to tailor, implement, and evaluate evidence-based interventions that take into account local cultures in an effort to prevent motor vehicle-related injury and death. The four piloted programs were successful at increasing seat belt use, increasing child safety seat use, and decreasing alcohol-impaired driving, as seen in the sample of accomplishments:

The Tohono O'odham Nation (TON) strengthened their seat belt use law in 2005. To support the new law, the TON Motor Vehicle Injury Prevention Program staff and Securing Tohono O'odham People Coalition members focused on increasing seat belt use on the Reservation with a comprehensive media campaign and work with Tribal Police to enforce the new law. They found that driver seat belt use increased 47% and passenger seat belt use increased 62% from 2005 to 2008.

The Ho-Chunk Nation Motor Vehicle Prevention Program partnered with local County police departments and implemented a comprehensive media campaign; conducted targeted education and training for police officers; hosted communitywide educational events; enhanced police enforcement; and conducted child safety seat clinics and checks. From 2005 to 2008, driver seat belt use increased 38%, passenger seat belt use increased 94%, and child safety seat use increased 65%.

The White Mountain Apache Tribe Motor Vehicle Injury Prevention Program focused on increasing seat belt use and decreasing alcohol-impaired driving by conducting DUI sobriety checkpoints, enhanced police enforcement, and a comprehensive media campaign. They found that driver seat belt use increased from 13% to 54% and passenger seat belt use increased from 10% to 32% from 2004 to 2008.

The San Carlos Apache Tribe Motor Vehicle Injury Prevention Program focused on reducing alcohol-impaired driving and increasing seat belt use among their tribal members through media campaigns, sobriety checkpoints, enhanced police enforcement, and local community events. Since 2004, DUI arrests increased 52%, driver seat belt use increased 46%, and motor vehicle crashes decreased 29%. In 2007, the San Carlos Tribal Council strengthened their seat belt and impaired driving laws.

The success of these pilot programs led to the next step of funding 8 additional tribes in FY 2010.

Public Health Surveillance Program Office, Office of Surveillance, Epidemiology, and Laboratory Services (OSELS) Data Sharing Agreement with the New Mexico Department of Health and the Navajo Area Indian Health Service

The new legal data sharing agreement between NMDOH and NAIHS made it possible for the new tribal epidemiologist to compile data requests from the NMDOH epidemiologists and New Mexico Health Policy Commission for record-level IHS hospitalization and emergency department data. The next step for the New Mexico Assessment Initiative Project in its work with their Navajo community is the full execution of the Albuquerque Area Indian Health Service (AAIHS) data sharing agreement, which will enable NMDOH to have access to all Navajo data within its jurisdiction. (The Navajo Nation in New Mexico is split into two IHS service areas: NAIHS and AAIHS.)

Navajo Nation Diarrheal Study, National Center for Emerging and Zoonotic Infectious Diseases (NCEZID)

Rates of infectious diarrhea among the Navajo Nation are high, likely due in part to poverty, limited access to healthcare, and geographic isolation. An additional challenge to this population is limited access to safe potable water; however, the association between water quality, water use patterns and gastroenteritis has to our knowledge never been studied. To address this gap, two hospitals were selected in the Navajo reservation to enroll patients that have been admitted or presented on an outpatient basis for acute infectious gastroenteritis. Hospital- or clinic-based controls presenting

with non-infectious complaints are matched to cases based on service unit of residence and age strata. Cases patients and controls will be surveyed on household water use practices including water source, volume consumed, transport methods and handling practices, and personal and household hygiene practices using a standardized questionnaire. Stool samples are being collected from case patients and controls and shipped to CDC for identification of bacteria, parasites, and viruses. Additionally, water samples are being collected from the primary source of drinking water for case patients and controls using the single-pass ultra filtration procedure developed by CDC. Water analyses include chlorine residual, *E. coli*, and a suite of waterborne pathogens (rotavirus, norvirus, *Campylobacter jejuni*, pathogenic *E. coli*, *Shigella*, *Cryptosporidium* spp., and *Giardia intestinalis*).

Interagency Agreement with IHS (NCIRD)

NCIRD has Interagency Agreements (IAA) that funds two FTEs that are placed with the Indian Health Service (IHS). Activities covered by the CDC/NCIRD and IHS IAA strengthen the partnership between IHS, CDC and tribes, ensure vaccine-related health insurance reforms are included in services provided at Indian, Tribal, and Urban (ITU) facilities, improve the quality of and access to care by providing access to vaccines to prevent disease, and ensure that information on federal immunization-related activities is available to all. Though we fund the salaries, IHS is responsible for their programmatic duties/activities. These activities include: immunization reporting, immunization software development and training, immunization data exchange between the immunization module in the Resource and Patient Management System (RPMS) and state immunization registries, influenza surveillance, influenza vaccination of Healthcare Personnel (HCP) initiative, IHS immunization policy, management of vaccine shortages and evaluation of impact research (in consultation with tribes and in accordance with IHS and tribal policies), emergency response activities.

Division of STD Prevention Funding Changes to Capture AI/AN (NCHHSTP)

The Division of STD Prevention collaborates closely with several CDC-funded Infertility Prevention Projects (IPP) to increase STD screening among AI/AN in the projects' respective states. More recently, with the latest Comprehensive STD Prevention Services (CSPS) application requiring states to document how they have reached out to AI/AN, we have been engaged with new IPP partners.

National Institute for Occupational Safety and Health (NIOSH) Funds Three AI/AN Programs

NIOSH provides funding to three program through our Office of Extramural Programs (OEP) where the purpose of the award is to primarily or substantially benefit American Indian Alaska Natives: A training project grant (TPG) to the University of Oklahoma Health Science Center / College of Public Health; the Model Farmer Dissemination Project with the University of New Mexico Health Sciences Center and a Continuing Education Grant with the Alaska Marine Safety Education Association (AMSEA).

DIVISION SPECIFIC ACTIVITIES

National Public Health Performance Standards Program and Tribal Public Health (OSTLTS)

CDC OSTLTS provides technical assistance and training to tribal entities interested in the National Public Health Performance Standards Program (NPHPSP) assessment or utilizing assessment data for improvement planning. On September 1, 2010 one staff person provided presented on utilizing NPHPSP for community-based improvement at

the Northern Plains Tribal Public Health Summit in Sioux Falls, SD. In addition, the program makes available assessment reports to tribes who have completed an NPHPSP assessment; two tribes completed an NPHPSP assessment in 2010.

Healthy People 2020 Public Health Infrastructure Workgroup (OSTLTS)

CDC OSTLTS co-leads the PHI topic area of Healthy People 2020 with HRSA. Of the 17 objectives in the PHI topic area, 8 objectives have a tribal-related component; there have been challenges in measuring similar objectives in the past through HP2010. CDC has convened a subgroup (with involvement of HHS, OMH, IHS and other representatives of the AI/AN community) to address AI/AN data collection issues related to this topic area and to ensure accurate and relevant data that will assist in measuring AI/AN public health objectives.

National Voluntary Accreditation and Tribal Health Departments (OSTLTS)

CDC OSTLTS is supporting the development and launch of a national voluntary accreditation program for public health departments. Tribal health departments are eligible to apply. The program will be launched in late 2011. While all development and testing activities relate to the overall program, during this past year three specific activities were focused exclusively on vetting and testing the accreditation standards, measures and process in tribal settings: a tribal "think tank" in December 2009, beta testing of the accreditation program in three tribal health departments (Navajo Nation, Cherokee Nation, and Keewenaw Bay Tribe) in summer 2010, and a Tribal Accreditation Work Group meeting in September 2010. National Native

HIV/AIDS Awareness Day-March 20, 2010 (NCHHSTP)

The Division of HIV/AIDS Prevention supports the National Native American AIDS Prevention Center in hosting this annual event for the past 5 years. The event highlights building awareness of HIV/AIDS among native communities, and advances strategies for increased testing and access to treatment.

Native American Community Health Center (NCHHSTP)

This project was funded to provide effective HIV prevention services to young (up to age 24) men of color who have sex with men (YMCSM) and young (up to age 24) transgender persons of color who are at high risk for HIV infection or transmission. Major activities include the following: implement one of nine adapted effective behavioral interventions with high risk individuals; implement one of the following Public Health Strategies for high risk individuals: Comprehensive Risk Counseling and Services (CRCS) or Counseling, Testing, and Referral (CTR) services; and/or implement a Demonstration Project (a locally developed, theory-based HIV prevention program).

The National Native American AIDS Prevention Center (NCHHSTP)

This project was funded to provide capacity building assistance (CBA) to HIV prevention planning groups, community-based organizations, health departments and other HIV prevention stakeholders. It focuses on the following goals: 1) Strengthening Organizational Infrastructure for HIV Prevention: Improve the capacity of Community Based Organizations (CBOs) to strengthen and sustain organizational infrastructures that support the delivery of effective HIV prevention services and interventions for high-risk racial/ethnic minority individuals; and 2) Strengthening Interventions for HIV Prevention: Improve the capacity of CBOs and Health Departments to implement, improve, and evaluate HIV prevention interventions for high-risk racial/ethnic minority

individuals of unknown serostatus, including pregnant women, and people of color who are living with HIV/AIDS and their partners

HIV Prevention-Aberdeen Area Tribal Chairmen's Health Board (NCHHSTP)

This project was funded to provide HIV prevention services for members of racial/ethnic minority communities in which there may be a high risk for HIV infection. Prevention services will include behavioral interventions [i.e., Evidence-based Behavioral Interventions (EBIs), Comprehensive Risk Counseling and Services (CRCS)], HIV Counseling, Testing, and Referral (CTR) Services. Funding for the first year also supports outcome monitoring of selected behavioral interventions (Community Based Organization Monitoring and Evaluation Project).

HIV Prevention - Indigenous Peoples Task Force (NCHHSTP)

This project was funded to provide HIV prevention services for members of racial/ethnic minority communities in which there may be a high risk for HIV infection. Prevention services will include behavioral interventions [i.e., Evidence-based Behavioral Interventions (EBIs), Comprehensive Risk Counseling and Services (CRCS)], HIV Counseling, Testing, and Referral (CTR) Services.

Indian Health Service National Sexually Transmitted Disease Program (NCHHSTP)

Partnership between National Center for HIV, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) and Indian Health Service (IHS) provides a mechanism to enhance collaboration in the area of STD prevention and control in AI/AN populations. The over arching goals of the IHS National STD Program are to: raise awareness of STDs among AI/AN as a priority health issue, support partnerships and collaborations with state STD programs, IHS, tribal, and urban Indian health programs (I/T/U), and other public health agencies, support improvement of I/T/U, state, and local STD programs for AI/AN, increase access to up-to-date STD training for clinicians and public health practitioners, and support and strengthen surveillance systems to monitor STD trends.

Native STAND—Students Against Negative Decisions (NCHHSTP)

One initiative is to raise awareness of STDs among AI/AN as a priority health issue. Native STAND—Students Against Negative Decisions —is a peer education curriculum for healthy decision making for Native youth. This innovative curriculum was developed by several collaborating entities, including the National Coalition of STD Directors (NCSD), Mercer University School of Medicine, CDC's Division of STD Prevention, and IHS's National STD Program. The curriculum was piloted at four Bureau of Indian Education residential schools during the 2009-2010 school year. The evaluation was led by Project Red Talon, the STD/HIV prevention project of the Northwest Portland Area Indian Health Board. The evaluation showed that Native STAND effectively educated and empowered Native high school students at the four pilot sites to help their peers address sensitive adolescent health issues. Native STAND is now being offered as one of Planned Parenthood of Minnesota, North Dakota, and South Dakota (PPMNS) programs for teens in Bemidji and Duluth, MN. The next steps are to work with the Northwest Portland Area Indian Health Board to implement a variation of Native STAND with a cohort of students at the local junior high school that will include training in media literacy and video production for participating youth.

Get Yourself Talking (GYT) STD Screening Campaign (NCHHSTP)

CDC and IHS collaborated to promote and expand the reach of the 2009 and 2010 Get Yourself Talking (GYT) STD screening campaign in Indian Country. Together, we

worked to inform, guide, and disseminate GYT-related materials developed for Native communities and IHS, Tribal, and Urban Indian (I/T/U) health care providers. Collaborative partners worked with websites frequented by AI/AN to post GYT materials including the AI/AN-specific clinic locator widget (these websites were Native American Times, Indian Country Today, and Indianz.com). The STD Widget 7-300 (specific to AI/AN) received the highest number of hits during the initial kick off month of the GYT campaign (April 2010) compared to all other widgets having received over 18,000 hits. In addition, informational briefings for Tribal Colleges and Universities (TCU) to provide details regarding GYT and screening event opportunities were held.

It's Your Game, Keep It Real Project (NCHHSTP)

It's Your Game, Keep It Real Project represents a collaboration between the University of Texas PRC, Indian Health Service, Alaskan Native Tribal Health Consortium, Northwest Portland Area Indian Health Board, Intertribal Council of Arizona, Oregon State Health University (OHSU) PRC, Bureau of Indian Education, and Tribal Boys and Girls Clubs collectively provides extensive experience in developing and testing sexual health programs for middle-school aged youth and in conducting youth-based research in AI/AN communities. The goal of this 4-year Special Interest Project (SIP) is to adapt and evaluate the effectiveness of an Internet-based HIV/STI, and pregnancy prevention curriculum for American Indian/Alaska Native (AI/AN) middle school-aged youth (12-14 years).

National Chlamydia Coalition awarded the Region X IPP (NCHHSTP)

The National Chlamydia Coalition awarded the Region X IPP with funding to develop and implement protocols for the standard delivery of STD screening and presumptive treatment for I/T/U. The use of standing orders will improve adherence to national STD screening recommendations as well as patient and partner management. This policy also includes guidance on Expedited Partner Therapy (EPT), presumptive treatment in symptomatic patients, and vaccination for HPV and HBV. We serve on the advisory group for this project. To-date, sample policy and standing orders have been developed, pilot sites have been identified, and plans to begin the piloting are underway. Program tools will be tested in multiple sites in AZ, AK, CA, OR, and WA. Newly developed materials will be made widely available to providers across Indian Country following the pilot-phase to promote, strengthen, and routine STD screening activities among AI/AN.

Alaska Native Tribal Health Consortium-Viral Hepatitis Research Project (NCHHSTP)

Division of Viral Hepatitis currently collaborates with the Alaska Native Tribal Health Consortium to research the natural history and prevention of viral hepatitis among Alaska Natives. Goals include: evaluating the persistence of antibodies after hepatitis A vaccination among Alaska Natives who receive the primary vaccination series 9 years or more ago as infants (<2 years of age) and young children, evaluating the long term protection afforded by the plasma-derived and recombinant hepatitis B vaccines among Alaska Natives who received primary vaccine series 15 years or more ago, studying the natural history of chronic hepatitis B using an established registry or cohort of Alaska Natives and data from their medical records followed over time, and studying the natural history of chronic hepatitis C using an established registry or cohort of Alaska Natives and data from their medical records followed over time.

Investigation of Unregulated Drinking Water Exposures, Use, and Hauling Practices in Alaska Native Villages (NCEH)

The use of unregulated drinking water sources represents a potential public health risk for communities with drinking water sources not routinely treated or tested for biological or chemical contaminants. Though some rural Alaskan villages are being connected to regulated community water, many villages still rely on water hauling from unregulated water sources for their drinking water. This study investigated water quality and contamination of unregulated drinking water sources used by Alaskan villages in the Yukon-Kuskokwim Delta region which included rivers, wells, tundra ponds, and other surface water sources. The primary objectives of this study were: 1. To characterize water quality in various surface drinking water sources and other unregulated water sources in four rural Alaska villages; 2. To characterize drinking water quality in homes; 3. To evaluate household water source, use, storage and handling practices to assess public health risks and develop appropriate public health education messages; and 4. To determine if water hauling behaviors or water contamination risks vary between summer and winter seasons. Working with the Alaska Native Tribal Health Consortium (ANTHC), CDC Arctic Investigations Program, and the local communities, the National Center for Environmental Health (NCEH) Health Studies Branch (HSB) identified unregulated drinking water sources near the selected villages. Households were visited by field teams in both the winter (March, 2010) and summer (August, 2010) seasons with a total of 270 households participating during winter sampling and 259 households participating during the summer sampling period. One adult in each household was interviewed in-person regarding drinking water source, use, hauling, and storage practices, piped water availability, and knowledge and beliefs regarding water safety. Households that hauled any drinking water from an external source also provided water samples for bacterial (total coliform and *E. coli*) and heavy metals analysis. Potential unregulated drinking water sources were also sampled and tested for a panel of inorganic chemicals, concentrations of persistent organic chemicals (e.g., PCBs, dioxins, chlorinated pesticides), and microbial contaminants (e.g. total coliform, *E. coli*, *Cryptosporidium*, *Giardia*, norvirus, enterovirus, and *Salmonella)*. The regulated water treatment facility in each village was also tested for all of the above contaminants for comparison. These results are still being analyzed and will help us identify public health issues and further develop important health messages to promote safe water use in Alaskan Native communities.

Navajo Nation Safe Water Use and Water Hauling Community Health Education Campaign (NCEH)

The National Center for Environmental Health (NCEH) Health Studies Branch (HSB) has also been involved in Navajo Nation-wide health education activities, in partnership with the Navajo Nation Environmental Protection Agency and Navajo Nation Division of Health. The community health educational campaign activities include crafting radio advertisements about safe drinking water and safe water hauling practices which incorporated appropriate Navajo cultural references and were presented in both the Navajo and English language. In addition, safe water informational brochures were created for distribution to the community. Environmental health booths are being established at Navajo Nation Fairs to provide safe water information in educational brochure and magnet giveaway format, hands-on exhibits such as microscopes to allow people to visibly see organisms in unsafe water, and health personnel at the booths to answer health or safe water use and water hauling questions.

Navajo Nation Resource and Patient Management System Database (NCEH)

The National Center for Environmental Health (NCEH) Health Studies Branch (HSB) is investigating the utility of the Indian Health Service Water and Sanitation database as a means to investigate increased risks for contracting skin and respiratory infectious diseases for a household on the Navajo Nation when adequate water and sanitation are absent. As a continuation of the cross-sectional study performed in rural Native Alaskan villages, which demonstrated higher risks for contracting skin and respiratory infectious diseases when adequate water and sanitation are absent, this study is investigating the utility of the IHS Water and Sanitation database as a means to conduct a longitudinal study looking at the health endpoints in tribal locations outside of Alaska. The database will be used to locate areas throughout IHS where water or sewer service is insufficient, initially focusing on the Navajo Nation. Conducting a longitudinal study, as well as conducting the follow-up study outside of Alaska, will better assess the association between insufficient water and sanitation to infectious disease in tribal areas.

North Cheyenne Tribe Mercury Study (NCEH)

The Cheyenne River Sioux Tribe, in partnership with the University of New Mexico Community Environmental Health Program, its director Dr. Johnnye Lewis and Dr. Jeff Henderson of the Black Hills Center for American Indian Health, determined that exposure to mercury in the fresh water rivers, lakes, and dammed ponds on the reservation was a major environmental health concern. Tribal community concerns included immune function and autoimmune disease as potentially related outcomes. Although local waters had been posted with mercury fish consumption advisories for some time, no study of community health had been conducted. In 2010, the NCEH Division of Laboratory Sciences Inorganic and Radiation Analytical Toxicology Branch helped assess community exposure to mercury by analyzing 75 human blood samples for total mercury and an additional 8 samples for different species of mercury.

Navajo Metals Study (NCEH)

Access to safe drinking water on Navajo Nation is particularly costly and problematic due to the regional hydrogeology (water sources are limited, deep and highly mineralized). In addition, Navajo households tend to be geographically dispersed and many people live in remote, low density communities, limiting the feasibility of providing public utilities to homes. To help assess the extent of human exposure to potential drinking water contaminants, the NCEH Division of Laboratory Sciences Inorganic and Radiation Analytical Toxicology Branch analyzed the concentration of several relevant metals in samples from the Nevada Arsenic Study DLS measured arsenic, barium, beryllium, cadmium, cobalt, cesium, molybdenum, lead, platinum, antimony, thallium, tungsten and uranium in 26 human samples and provided urine arsenic speciation analytical laboratory results for 2 samples.

Tobacco National Networks (NCCDPHP)

The Office on Smoking and Health funds six networks including one that serves American Indian/Alaska Native (AI/AN) populations. The AI/AN National Network provides leadership, expertise and promotion of policy-related initiatives (including environmental and systems change) and increase utilization of proven or potentially promising practices when available or appropriate. The AI/AN Network participates as a member of the consortium of national networks that facilitates a process by which network participants will inform the tobacco prevention community about: the depth of industry targeting; the gaps in data used to describe the burden of tobacco; and strategies to implement proven or promising interventions in specific populations. The

AI/AN Network will build capacity in tribal communities by recruiting individuals and organizations to facilitate learning and information sharing across and within network participants. Successes and lessons learned from this initiative includes the development of policies that restrict tobacco use, an increase in the participation of tobacco prevention efforts by underserved populations, and the development of population-specific tools that tribal communities can use in commercial tobacco prevention efforts.

American Indian/Alaska Native Adult Tobacco Survey Training (NCCDPHP)

CDC's Office on Smoking and Health and the National Native Commercial Tobacco Abuse Prevention Network are collaborating on a series of trainings tailored for tribes who wish to implement their own American Indian Adult Tobacco Survey (AI ATS). The training stresses the importance of tribal-specific surveillance in informing and improving comprehensive commercial tobacco prevention and control at the tribal health system level and provides the knowledge and tools that allow tribes to implement this surveillance system. Tribes served by the Inter-Tribal Council of Michigan and the Tribal Support Centers for Tobacco Programs are committed to working collaboratively on trainings that will be held at least twice per year. Ongoing technical assistance for tribes in the area of surveillance implementation and data analyses will also be provided.

Using Traditional Foods and Sustainable Ecological Approaches for Health Promotion and Diabetes Prevention in AI/AN Communities (NCCDPHP)

Towards the goals of: 1) supporting community "*use of traditional foods and sustainable ecological approaches for diabetes prevention and health promotion in American Indian and Alaska Native communities;"* and 2) engaging communities in identifying and sharing stories of healthy traditional ways of eating, being active, and communicating health information and support for diabetes prevention and wellness, seventeen (17) cooperative agreements were awarded at approximately $100,000 each for 5 years, from 2008-2013, to four tribal corporations (Aleutian Pribilof Islands Association - AK, Southeast Alaska Regional Health Care Consortium, United Indian Health Services – CA, Confederated Tribes of Siletz Indians - OR), one urban Indian health program (Indian Health Care Resource Center of Tulsa), one tribal community action organization (Tohono O'odham Community Action), one tribal college (Salish Kootenai College), and ten (10) rural reservation communities (Eastern Band of Cherokee Indians - NC, Catawba Cultural Preservation Project - SC, Cherokee Nation - OK, Nooksack Indian Tribe - WA, Prairie Band Potawatomi Nation - KS, Santee Sioux Nation - NE, Sault Ste Marie Tribe of Chippewa Indians - MI, Standing Rock Sioux Tribe – ND/SD, Red Lake Nation - MN, Ramah Band of Navajo - NM.)

The Eagle Books (NCCDPHP)

CDC collaborated with the Tribal Leaders Diabetes Committee, Indian Health Service, and indigenous authors/artists to develop The Eagle Books, a series of four books that teach children about diabetes prevention and healthy living. Over 2 million books have been distributed to over 1000 AI/AN health and school organizations. Eagle Books and animated DVDs of books are included in the K-4 lessons of the Diabetes Education in Tribal Schools (DETS) Curriculum. The next set of Eagle Books for middle school children is currently being developed and they will include chapter books, graphic novels and comics.

Diabetes Education in Tribal Schools Curriculum (NCCDPHP)

Since 2001, the National Institutes of Health, NIDDK, in partnership with the Tribal Leaders Diabetes Committee, CDC Native Diabetes Wellness Program, the Indian Health Service, and 8 tribal colleges and universities (TCUs), have developed the K-12 culturally based science *Health is Life in Balance Diabetes Education* in Tribal Schools curriculum lessons. The TCUs and university partners are providing teacher development training through August 2011. CDC NDWP plans to conduct an in-depth qualitative on site evaluation of the DETS Health is Life in Balance curriculum and original Eagle Books in 12 communities over three years, starting in 2011.

Intergovernmental Personnel Agreements (IPAs) for GIS Maps and External Evaluation for Grantees Activities and Eagle Books (NCCDPHP)

The Native Diabetes Wellness Program has two IPAs to: 1) develop GIS maps both for Eagle Book distribution and for use by the 17 *Traditional Foods and Sustainable Ecological Approaches to Health Promotion and Diabetes Prevention* grantees to map gathering, hunting, horticulture, cultivation, and garden activities; and 2) provide external evaluation assistance for the 17 Traditional Foods grantees local data collection strategies, analysis of aggregate data, and review of the new middle school Eagle Books for cultural appropriateness of the diabetes presentation messages.

National Breast and Cervical Cancer Early Detection Program (NBCCED)- Funding to Tribal Organizations (NCCDPHP)

In FY 2010, the NBCCEDP received $194.1 million which supports all 50 states, the District of Columbia, 5 U.S. territories, and 12 American Indian/Alaska Native tribes or tribal groups to provide clinical breast exams, mammograms, pelvic exams, and Pap tests to women in need, such as those who are uninsured, have low incomes, or have health insurance that does not pay for screening. The program also provides diagnostic follow-up for abnormal screening results and treatment referrals if cancer is diagnosed. Approximately 5% of women served are AI/AN women. Since its inception in 1991, the NBCCEDP has provided more than 8 million breast and cervical cancer screening exams to more than 3.3 million women. The Indian/Alaska Native tribes or tribal groups who receive funding are: Arctic Slope Native Association Limited, Cherokee Nation, Cheyenne River Sioux Tribe, Hopi Tribe, Kaw Nation of Oklahoma, Native American Rehabilitation Association of the Northwest, Inc., Navajo Nation, Poarch Band of Creek Indians, South East Alaska Regional Health Consortium, South Puget Intertribal Planning Agency, Southcentral Foundation, Yukon-Kuskokwim Health Corporation

National Comprehensive Cancer Control Program (NCCCP)-Funding to Tribal Organizations (NCCDPHP)

In FY 2010, the NCCCP received $20.7 million to support 50 states, the District of Columbia, 7 tribes and tribal organizations, one territory, and 6 U.S. Affiliated Pacific Islands to develop and implement policy, systems-level or environmental changes aimed at preventing cancer, detecting cancers early when they are more treatable, increasing access to treatment, and improving the quality of life of cancer survivors These activities are intended to reduce the burden of cancer through primary prevention (e.g. smoke-free policies), detecting cancers early when they are more treatable (e.g. cervical and colorectal cancer screening), increasing access to quality cancer treatment, and addressing cancer survivors' public health needs. In FY 2010, the Cherokee Nation tribal organization was one of 13 demonstration programs funded by the NCCCP to develop a focused policy agenda with a goal of implementing at least 3 policy or systems change interventions by the end of the 5-year project period.

Colorectal Cancer Control Program (CRCCP)-Funding to Tribal Organizations (NCCDPHP)

In FY 2010, The Colorectal Cancer Control Program (CRCCP) awarded $26.9 million to 25 states and 4 tribal organizations to increase population-wide colorectal cancer screening through removing barriers to screening and to provide colorectal cancer screening services to low-income men and women aged 50 to 64 years who are underinsured or uninsured for screening when no other insurance is available. Funding will also support diagnostic follow-up, patient navigation, data collection and tracking, public education and outreach, provider education, and evaluation. Four tribal organizations – the Alaska Native Tribal Health Consortium, the Arctic Slope Native Association, South Puget Intertribal Planning Agency, and the Southcentral Foundation – were funded as CRCCP sites after a competitive review process. These sites will work to address disparities among AI/AN men and women, who currently have the second highest incidence rates colorectal cancer in the U.S.

National Program of Cancer Registries Data Link with IHS to Ensure Accurate Reporting

In 2010, the NPCR appropriation of $51 million supported central cancer registries in 45 states, the District of Columbia, Puerto Rico, and the U.S. Pacific Island jurisdictions. These data represent 96% of the U.S. population. The National Program of Cancer Registries provides data on cancer incidence for the U.S. population. In collaboration with NCI's SEER program, 100% of the U.S. population is covered. In order to accurately estimate the cancer burden in the American Indian/Alaska Native population, researchers must have access to cancer patient data that accurately identifies patient race. In recent years, some central cancer registries and geographic areas have reported the misclassification of American Indians/Alaska Natives, decreasing the accuracy and reliability of cancer incidence data. CDC took on this issue by linking data between the IHS patient registration database and central cancer registry data, including a linkage in 2007 with all NPCR and SEER supported registries. CDC continued this work to improve data on race and reduce misclassification, working with 34 central cancer registries. This work is critical to informing researchers, policymakers, and communities about the burden of cancer.

Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN) funded Tribal Programs (NCCDPHP)

The WISEWOMAN (Well-Integrated Screening and Evaluation for Women Across the Nation) Program aims to reduce cardiovascular disease in low-income, uninsured, or underinsured women ages 40–64 through risk factor screening which includes blood pressure, cholesterol, glucose, height, weight, personal medical history, health behavior, and readiness to change. To be eligible, women must first be enrolled in CDC's National Breast and Cervical Cancer Early Detection Program. Culturally tailored lifestyle interventions targeting nutrition, physical activity, and smoking are promoted. The interventions vary across programs, but are all designed to promote lasting, healthy lifestyle changes. Between July 2008 and June 2010, the WISEWOMAN Program (Well-Integrated Screening and Evaluation for Women Across the Nation) screened 78,257 women nationally. American Indian/Alaskan Natives (AI/AN) represented 4.75% (3,714) of those screened, of which 65.4% (2,428) participated in a lifestyle intervention. WISEWOMAN funds two Tribal programs: Southeast Alaska Regional Health Consortium (SEARHC) with headquarters in Sitka, and the Southcentral Foundation (SCF) with headquarters in Anchorage. SEARHC is a non-profit, Native-administered health consortium established in 1975 to represent Tlingit, Haida, Tsimshian and other Native people in Southeast Alaska. Southcentral Foundation is an Alaska Native-owned healthcare organization serving the AI/AN population living in Anchorage, the Mat-Su

Valley, and 60 rural villages in the Anchorage Service Unit. Between July 2008 and June 2010, SEARHC screened and provided risk reduction counseling to 1,677 women of which 76 % of participants were AI/AN. Between July 2008 and June 2010, the Southcentral Foundation WISEWOMAN program screened 1,187 women for cardiovascular disease risk factors of which 100% of participants were AI/AN.

WISEWOMAN funded State Programs Impacting AI/AN Populations (NCCDPHP)

The South Dakota WISEWOMAN Program has increased Native American Women participation from 16% to 18% in two years. The South Dakota WISEWOMAN Program screened 6,987 women between July 2008 and June 2010 of which 923 (13.2%) were Native American. The WISEWOMAN Program attributes this increase to outreach efforts among Native American Women at Indian Health Services (IHS) local community clinics and tribal health boards. The outreach efforts are conducted by a contracted representative from the Native American community. The representative worked with tribal governments to draft tribal resolutions to improve and promote health of Native American women. These resolutions increased awareness in the local Native American communities about the importance of cardiovascular disease risk factor screening and lifestyle interventions in traditional and non-traditional settings. The WISEWOMAN program in collaboration with their state tobacco program developed tobacco cessation materials specifically for their Native American population.

Strategic Alliance for Health (NCCDPHP)

The Strategic Alliance for Health (SAH) program seeks to build community capacity and improve health through sustainable, innovative, and evidence-based community health promotion and chronic disease prevention interventions that promote policy, systems, and environmental changes. Two American Indian tribes are funded as SAH communities:Cherokee Nation SAH program addresses chronic disease and associated risk factors, including obesity, diabetes, cardiovascular disease, physical inactivity, poor nutrition, tobacco use, and exposure to second-hand smoke. In FY 2010, the program successfully supported the adoption of a tobacco-free policy for outdoor public places in the City of Tahlequah, and is creating an Implementation Guide to describe the campaign's step-by-step process so other communities might replicate its success in the future. To reduce the incidence of and complications from cardiovascular disease, diabetes, and obesity in the Anishinaabe community, the Sault Ste. Marie Tribe of the Chippewa Indian SAH program develops culturally-specific approaches to promote physical activity and healthy eating, reduce tobacco use and exposure, and foster improved access to quality healthcare. The program emphasizes leveraging partnerships between Sault Tribal and non-Tribal partners. Strategies include: establishing non-motorized transportation infrastructure (bike lanes, sidewalks, and crosswalks), offering and promoting healthy food and beverage options at meetings, casinos, corner stores, farmer's markets, and community gardens, increasing physical activity in afterschool programs, and increasing tobacco and smoke-free tribal venues in parks and housing units. The program recently worked with their tribal Housing Authority to adopt a smoke-free housing policy and designate 17 units smoke-free, setting an important precedent and increasing awareness about the dangers of second-hand smoke. In addition, the program helped implement a tobacco-free policy for a public school district, impacting 700 students.

Racial and Ethnic Approaches to Community Health across the U.S. (REACH U.S)

REACH U.S. is a cornerstone of CDC's efforts to eliminate racial and ethnic health disparities. The program utilizes coalition-led, community-based participatory

approaches to implement and evaluate innovative programs that improve health in communities, health care settings, schools, and worksites. Six REACH projects focus on health disparities affecting American Indians:

REACH - Choctaw Nation of Oklahoma (NCCDPHP)

The Choctaw Nation of Oklahoma "Lifetime Legacy Program" focuses on cardiovascular disease as well as the intervening variables of childhood obesity, tobacco and methamphetamine abuse. After successfully building their capacity and infrastructure, Lifetime Legacy is coordinating presentations and trainings in the community to increase awareness and readiness for change. The program is working with tribal and county leaders to consider institutional and community policy changes to support access to healthy eating and increased physical activity.

REACH - Eastern Band of Cherokee Indians (NCCDPHP)

The Eastern Band of Cherokee Indians "Cherokee REACH Coalition" works to reduce the burden of Type II diabetes through the promotion of physical, emotional and cultural well being. Viewing poverty, racism, and inactive lifestyles as major contributors to health disparities related to diabetes, the Coalition engages community members and works with key formal and informal opinion leaders to shift social norms and create change among individuals, organizations, systems, and policies. Cherokee REACH has contributed to successful efforts to improve health-supportive nutrition and curriculum changes; the program is also involved in efforts to revive a culturally significant and historical trail to increase physical activity in the local community.

REACH - Inter-Tribal Council of Michigan (NCCDPHP)

To reduce cardiovascular and diabetes-related disparities, the Inter-tribal Council of Michigan "Reaching Toward a Healthier Anishinaabek" program supports tribal communities with development of culturally tailored, community-based interventions. The Hannahville, Saginaw Chippewa, and Bay Mills tribes have initiated a wide range of activities, for example: implementing a school-based diabetes education program, developing worksite wellness initiatives and programs, enhancing access to facilities and classes to increase physical activity opportunities, and working with local and federal partners to support walkable communities through the creation of local and regional trail systems. In addition, REACH tribal partners continue to work with local health systems to minimize barriers in access to health care.

REACH- Northern Arapaho Tribe (NCCDPHP)

The Northern Arapaho Tribe "Wind River Reservation Infant Mortality Prevention Project" works to increase awareness, strengthen inter-agency coordination and partnerships, and improve access to health care services. The project hopes to increase the number of Northern Arapaho and Eastern Shoshone women who initiate early prenatal care and sustain it throughout their pregnancies. Coalition members and the programs they represent have worked to address programmatic barriers to heath care and to make tribal policies more supportive of families. In addition, a *Families of Tradition* curriculum was designed to re-educate community parents on the positive values and beliefs of Native traditions that were silenced due to colonization. By understanding the history of their ancestors, participants are able to recognize multi-generational trauma, break unhealthy cycles, and start a new beginning.

Southern Plains REACH US (NCCDPHP)

The Oklahoma State Department of Health "Southern Plains REACH US" program works with tribal communities across Oklahoma, Texas, and Kansas to reduce the risk of diabetes and cardiovascular disease. As a Center for Excellence in the Elimination of Health Disparities, the project funds and supports tribal organizations as "legacy communities" to address nutrition, physical activity, and tobacco control. For example, tribal partners have worked with schools to create Coordinated Approach to Child Health [CATCH] programs, they are engaged in ongoing efforts to implement and enforce tribal, business or institutional policies regarding tobacco control and prevention, and they have awarded Healthy Business awards to three tribal or tribally related organizations.

Center for Excellence in the Elimination of Health Disparities (NCCDPHP)

As another Center for Excellence in the Elimination of Health Disparities, the University of Colorado at Denver develops community and clinically-based interventions to reduce cardiovascular disease risk among urban American Indians. Intervention activities include assessment, education, clinical management, and training. The project has revised the *Gift of the Health Heart* curriculum, and classes have begun in associated Indian health programs. Coalitions have received training on the *Fit Friendly* program, and member organizations are pursuing policy changes to provide a healthier work environment for their employees. The program is also establishing and networks with non-coalition partners to expand its reach, increase opportunities for collaboration, and identify potential sources of funding and training for coalition members.

South Dakota Tribal Pregnancy Risk Assessment Monitoring System (PRAMS) Project

The Yankton Sioux Tribe (YST) and the Aberdeen Area Tribal Chairmen's Health Board (AATCHB) identified maternal and child health as the highest health priority in response to persistently high rates of infant mortality. In South Dakota from 2002 to 2004, American Indians made up 18.1% of births, but accounted for 34% of infant deaths. The South Dakota Tribal (SDT) PRAMS initiative is a unique PRAMS project collecting information exclusively from AI women (and mothers of AI infants) who recently gave birth to a live infant in SD, and Sioux County North Dakota. PRAMS is an ongoing, population-based risk factor surveillance system initiated and designed to identify and monitor selected maternal experiences and behaviors that occur before and during pregnancy and in the child's early infancy among women who deliver live born infants. In this project, CDC provided technical assistance including development of a model protocol for data collection, assistance with question design, survey instrument development, and training on human subjects' protections and telephone interviewing. CDC also provided and installed data entry software and survey tracking software, conducted on-site training of staff on the software, and gave on-going technical assistance on the systems. The 3-year grant funding ended in April of 2009, and a no cost extension through April of 2010 was approved. Currently, CDC provides ongoing consultation regarding data analysis and data dissemination activities.

Secretary's Initiative - Department of Health and Human Services, Closing the Health Disparities gap: Sudden Infant Death Syndrome and Infant Mortality Initiative, AI/AN Projects (NCBDDD)

This initiative provided 1.5 million dollars annually in support of maternal and child health epidemiologists at 7 Tribal Epidemiology Centers (TEC) and supported infant mortality risk reduction projects. This program was modeled on the CDC Maternal Child Health (MCH)-epidemiology program that supports resident CDC epidemiologists in state health departments. Over the 3-year project life, 7 TECs established functional

MCH epidemiology units that initiated tribal infant mortality surveillance. Each of the 3 project years and in the ensuing years, TEC sessions were held at the national annual MCH-epidemiology (MCH-Epi) conference. In February 2008, TEC MCH epidemiologists presented a summary of their accomplishments at CDC's Tribal Consultation Advisory Committee Meeting. Although project funding ended, technical consultation continues to be provided to TECs to build epidemiologic capacity.

Improving Health and Educational Outcomes of Young People (NCCDPHP)

CDC's Division of Adolescent and School Health (DASH) supports state, territorial, and local agencies and tribal governments to help build and strengthen their capacity to improve child and adolescent health. As part of these efforts, three tribes were awarded cooperative agreements:

Cherokee Nation funded by DASH to provide HIV Prevention Education (NCCDPHP)

The Cherokee Nation Health Services Group and the Cherokee Nation Education Services Group collaborate with multiple community partners to improve the health of young people in the 14-county Cherokee Nation Tribal Jurisdictional Service Area in northeastern Oklahoma. The Cherokee Nation receives funding from CDC's Division of Adolescent and School Health to provide HIV prevention education. In 2009-2010, the Cherokee Nation coordinated with local drug prevention coalitions to link HIV prevention messages and activities; distributed model HIV prevention policies, recommendations, and guidelines to area schools; selected several science-based HIV/STD/Teen Pregnancy prevention curricula and worked with schools to help them implement one of these curricula; provided professional development to teachers, nurses, and counselors on dealing with the prevention of sexual risk behaviors; and collaborated with the Oklahoma State Department of Education to successfully conduct the School Health Profiles survey to obtain representative information about current school health policies and practices

Cherokee Nation funded to conduct the Youth Risk Behavior Survey (YRBS) (NCCDPHP)

The Cherokee Nation also receives funding to conduct the Youth Risk Behavior Survey (YRBS). The goal of this program is to advance the knowledge of critical health related behaviors among high school students through data collection and dissemination. The Cherokee Nation conducted a YRBS in 2009 with technical assistance from CDC/DASH. To plan, promote, and disseminate results from the YRBS, the Cherokee Nation also collaborated with multiple community partners. In 2009, Cherokee Nation administered the YRBS in middle and high schools within the Tribal Jurisdictional Service Area to obtain data representative of students in grades 6-12. (Note, in 2009, the Cherokee Nation only obtained data representative of students in grades 6-8.) CDC/DASH also provided technical assistance during the planning phase for the 2011 administration of the YRBS.

Winnebago Tribe of Nebraska receives funding to conduct the Youth Risk Behavior Survey (NCCDPHP)

The Winnebago Tribe of Nebraska receives funding to conduct the Youth Risk Behavior Survey (YRBS). The goal of this program is to advance the knowledge of critical health related behaviors among high school students through data collection and dissemination. The Winnebago Tribe obtained weighted YRBS data in 2009 (allowing for generalized results); tribal leaders are currently reviewing the YRBS data for program planning purposes. CDC/DASH also provided technical assistance during the planning phase for the 2011 YRBS.

Nez Perce Students for Success Program (NCCDPHP)

The Nez Perce Tribal Government receives funding to plan and implement coordinated school health programs in local schools. The Nez Perce Students for Success Program is a collaborative effort between the Nez Perce Education Department, Nimiipuu Health, and four local school districts to support the development of coordinated school health Programs in four K-12 schools on the Nez Perce reservation. The Students for Success Program works to improve the health of children through planning and coordination of programs across and within agencies. From October 2009 – September, 2010 the Nez Perce Students for Success Program completed numerous activities, including developing and supporting school health councils; providing professional development, technical assistance, curriculum, policy and advocacy to support coordinated school health programs; delivering professional development, curriculum and technical assistance on standards and research-based quality physical education for all physical education teachers; providing technical assistance and information sessions to 100% of district-level school health council members on youth engagement and school connectedness research to improve student health programs; collaborating with the Idaho Department of Education on two joint projects and renewing their Memorandum of Agreement; and networking with five new tribal health and education agencies to promote CSH.

Pilot Study of the Association between Acute Gastroenteritis and Water Quality, Availability, and Handling Practices on the Navajo Nation (NCEZID)

This is a collaborative project with the National Center for Emerging and Zoonotic Infectious Diseases, the Indian Health Service, Johns Hopkins Center for American Indian Health, and the Navajo Nation. Epidemiologic data will be compiled and analyzed to evaluate associations between specific water use practices and presence of waterborne pathogens in drinking water with severe gastrointestinal illness.

Evaluation of Diarrheal Associated Admissions and Outpatient Clinic Visits- Children less than Five (NCIRD)

CDC is collaborating with the Indian Health Service to evaluate trends in diarrheal-associated admissions and outpatient clinic visits among children <5 years of age during fiscal-year 2004-2009. Data from this evaluation originates in the National Patient Information and Reporting System (NPIRS), the Indian Health Service national data repository. Additional components of the project include a validation of childhood vaccinations contained in NPIRS and a rotavirus vaccination effectiveness study in the Southwest and Alaska Areas.

Effective Strategies to Reduce Motor Vehicle Injuries among AI/AN (NCIPC)

This program is to design/tailor, implement and evaluate Native American community-based interventions with demonstrated effectiveness for preventing motor vehicle injuries within the following areas: 1) strategies to reduce alcohol-impaired driving among high risk groups; 2) strategies to increase safety belt use among low use groups; and 3) strategies to increase the use of child safety seats among low use groups. An overriding intent of this funding is to assist tribes in developing evidence-based effective strategies in programs, which take into consideration the unique culture of Native Americans. Funding was awarded to 8 grantees at approximately $70,000 per grantee. The period of performance is 9/2010 through 9/2014.

Arctic Investigations Program (NCEZID)

Arctic Investigations Program's (AIP) program mission is the prevention of infectious disease in people of the Arctic and subarctic, with particular emphasis on indigenous people's health. AIP coordinates disease surveillance and operates one of only two Laboratory Response Network labs in Alaska. Activities include: Sanitation services and infectious disease risk in rural Alaska: AIP was assessing infectious disease risk due to lack of sanitation services. The study produced significant results and members involved in the study now have in-home water and sewer service for the first time. Response to emergence of replacement pneumococcal disease in Alaska Native infants: AIP supported introduction of a new pneumococcal vaccine, PCV 13, in southwest Alaska. Usage results clarified that it provides protection for up to 75% of serious pneumococcal illnesses. High rates of pediatric dental caries in Alaska Native children: Dental caries among Alaska Native children represent a substantial and long-standing health disparity. Results of an AIP investigation concluded that pediatric dental caries are approximately 5 times more common in the region than for the general US childhood population. Support for Alaska Native Health Research: AIP promotes research activities by Tribal health organizations and supports Alaska Native/American Indian health researchers. Responding to pandemic H1N1 influenza in AI/AN populations: AIP established a functional unit within the CDC Emergency Operations Center, along with the Senior Tribal Liaison in the CDC Office of Minority Health, to address the H1N1 influenza pandemic among AI/AN people.

Study of association between water quality, water use patterns and gastroenteritis in the Navajo Nation (NCEZID)

Rates of infectious diarrhea among Navajo Nation residents are high, likely due in part to poverty, limited access to healthcare, and geographic isolation. Since studies had not been conducted to establish the co-relation, CDC, NCEZID, Division of Foodborne, Waterborne, and Environmental Diseases is addressing this along with John Hopkins University Center for American Indian Health.

Tick-borne Disease Control (NCEZID)

CDC, NCEZID, Division of Vectorborne Diseases is **w**orking with the Wampanoag tribe in MA to evaluate exposure to tularemia and other tick-borne diseases. Work to date has included a serosurvey and exposure assessment of Tribal members.

Rocky Mountain Spotted Fever (RMSF) Control (NCEZID)

Extensive cases of RMSF and some deaths on three Indian reservations in Arizona have surfaced where previously RMSF had not occurred. The Rickettsial Zoonoses Branch is investigating causes for heightened case fatality rates.

CDC/IHS American Indian and Alaska Native Heath Study Collaborations (NCEZID)

Ongoing epidemiologic collaborative projects with the Indian Health Service (IHS), Alaska Native Tribal Health Consortium (ANTHC), CDC Arctic Investigations Program (AIP), and other agencies/divisions and universities to describe disease burden and health disparities for overall and specific infectious diseases among American Indian and Alaska Native communities. Studies provide information for developing prevention strategies and reducing health disparities related to infectious diseases. Findings as a result of the studies have subsequently increased awareness of specific infectious diseases.

Division of High-Consequence Pathogens and Pathology Scientific Investigations and Analyses (NCEZID)

Selected examples include: ongoing monitoring and medical chart review of AI/AN CJD-reported cases; study of viral etiologies in respiratory hospitalizations among Alaska Native children; and conducting examination and analysis of Kawasaki syndrome (KS).

Dog Rabies Vaccination (NCEZID)

Ongoing collaborative investigation since October 2009 of public health risks associated with dogs in AI/AN communities. Investigation supports the fact that lower rabies vaccination coverage of domestic animals on reservations results in an increased risk for rabies exposure to humans.

The New Mexico Assessment Initiative (OSELS)

The New Mexico Assessment Initiative through Public Health Surveillance Program Office, Office of Surveillance, Epidemiology, and Laboratory Services hired a tribal epidemiologist during the 2009-2010 funding year to work directly with New Mexico's Navajo Nation community on community health assessment and data sharing issues.

Data Sharing Agreement - New Mexico Department of Health (NMDOH) and the Navajo Area Indian Health Service (NAIHS) (OSELS)

A legal data sharing agreement between the New Mexico Department of Health (NMDOH) and the Navajo Area Indian Health Service (NAIHS) was executed during the 2009-2010 funding year.

Alaska Native Tribal Health Consortium (ANTHC) (NCHHSTP)

Activities for 2010 include the following. DSTP initiated community-based participatory research to inform the development of youth-focus prevention materials and communication strategies and created an Alaska Native youth-focused website. DSTP secured funding to explore the use and acceptance of self-collected vaginal swabs among Alaska Natives, particularly among those residing in small remote communities and partnered with the John's Hopkins University's Iwantthekit.org program to facilitate a web-based testing requests in an effort to address perceived confidentially barriers to screening. In February 2010, DSTP made a follow-up site visit to assess the status of the assessment recommendations; while there we met with representatives from ANTHC, State of Alaska, CDC Arctic Investigations Program, Alaska State Medical Board, Alaska State Medical Board, Tribal Health Corporation Medical Directors, and the South Central Foundation. In April 2010, the IHS National STD Program encouraged Tribal and Alaska State partners to explore the possibility and potential benefits of requesting an EPIAID from the Division of STD Prevention to address an apparent gonorrhea outbreak and ongoing elevated rates of Chlamydia among Alaska Natives. The State of Alaska's Division of Epidemiology and Disease Prevention submitted a request to CDC/DSTDP for assistance. An EPIAID began in June 2010 and was staffed by two EIS officers. It included collection of survey data from medical providers, public health personnel, and patients regarding their acceptance of EPT as a means of partner treatment. Preliminary data analysis suggests widespread interest and acceptance of EPT, which would assist in the management of patients and partners in rural and urban regions of Alaska. We will continue to collaborate with the state and ANTHC to promote the implementation of EPT protocols once the data analysis is complete. In August 2010, the Division of STD Prevention participated in the first Statewide Tribal STD/HIV Taskforce meeting in Anchorage.

New Mexico and Arizona Tribal SNS Planning (OPHPR)

The states of New Mexico and Arizona are jointly working with the Navajo Nation to develop a Navajo Nation Strategic National Stockpile plan. In coordination with Arizona Department of Health, planning also is underway for a Navajo Nation receipt, stage and store (RSS) site to receive and house SNS materiel in the event that product is deployed during a public health emergency. This planning includes an integration of three New Mexico Indian Health Service (IHS) hospitals for alternate care sites as part of Navajo RSS plan. Furthermore, in New Mexico, 20 of 22 tribal medical countermeasure plans were developed that integrate point-of-dispensing sites between the IHS and the tribes. These plans demonstrate an integration of tribal and various IHS partners for the City Readiness Initiative and anthrax response.

Alaska Native Tribal Health Consortium (OPHPR)

These funds will be used by the Alaska Native Tribal Health Consortium (ANTHC) to coordinate plans and planning processes between the State of Alaska federal preparedness partners and the Alaska Native health system; to support the participation of Native health system personnel in state and federal bioterrorism exercises; to ensure the optimal utilization of resources, such as the Alaska Federal Health Care Access Network, and for development of communication plans, and production of communication strategies and messages for Alaska Native populations throughout the state.

Arizona Tohono O'odham Nation (OPHPR)

Collaboration with the Office of Border Health and Office of Infectious Disease Epidemiology to develop, implement and enhance the border-wide (cross-border) joint syndromic surveillance program for the purpose of early detection of emerging infectious diseases and syndromes of public health concern, including zoonotic diseases, food-borne illnesses, and fever and rash syndromes to include the following areas of interest.

Wampanoag (Tribal Nation) (**OPHPR)**

These funds will be awarded to the Wampanoag Tribe of Gay Head, a federally recognized American Indian tribal nation based on the island of Martha's Vineyard. The funds will be used to support emergency preparedness planning activities, trainings and exercises. Funds will also be used to support cooperative planning efforts and engagement with the tribe's public health and public safety partners in neighboring communities throughout the island, and with its partners in state government.

Fond du Lac Band of Lake Superior Chippewa (OPHPR)

Local public health agencies and tribal governments in Minnesota will use public health preparedness funding to support seven areas of preparedness and response. These include leadership, assessment, planning, surveillance and monitoring, response and recovery, workforce readiness, and communication. The specific activities required to receive funding from the Minnesota Department of Health (MDH) are developed by a state and local partnership group representing all of Minnesota's local public health agencies. MDH works directly with tribal governments to develop their specific activities.

Montana Blackfeet Reservation (OPHPR)

The Department of Public Health and Human Services contracts with local and tribal health jurisdictions (LHJ) to conduct preparedness activities. Funded activities will continue to enhance local public health capacity to respond to emergent situations, through planning, assessment and development of critical capacities in the areas of 1)

Planning and response, 2) Epidemiology and surveillance, 3) Health Alert Network (HAN)/Information technology, 4) Risk Communication, 5) Training and education and 6) Exercising current capabilities Funds that are not directly supporting staff are generally used to support other activities related to this agreement, including supporting and maintaining the HAN infrastructure and exercises.

Eastern Band of Cherokee Indians (OPHPR)

Eastern Band of Cherokee Indians (EBCI) is a state and federally recognized tribal government. North Carolina Division of Public Health (NCDPH) contracts with EBCI to support integration of tribal plans & plan revisions, regional response coordination, mutual aid & partnership building, & supplying elders and service providers with emergency preparedness kits.

Oklahoma City Area Tribal Health Board (OPHPR)

Oklahoma City Area Tribal Health Board (OCATHB) – Preparedness Planning and Intertribal Emergency Management Coalition (ITEMC) Support - Funding is provided to: Assist federally recognized tribes in preparedness planning as well as collaborate with CDC tribal liaison and Oklahoma State Department of Health (OSDH) in the development of pandemic influenza preparedness plans for twenty-five federally recognized tribes within Oklahoma; Provide technical assistance to the tribes as needed; Develop Continuity of Operations Plan (COOP) for the tribes; Maintain a preparedness matrix, which will be reviewed and approved by OSDH. The matrix must comply with National Incident Management System (NIMS) standards and participation in the ITEMC.

Confederated Tribes of Warm Springs Reservation of Oregon (OPHPR)

Contract for development of tribal public health preparedness leadership infrastructure. These funds will be used to assist the state and tribes to create a strategic plan for tribal public health preparedness which will inform and focus future tribal preparedness activities and support. Includes identifying a Preparedness coordinator, developing a tribal capacity assessment for public health preparedness, assessment for Pandemic Influenza Planning, drafting and submitting an Emergency Support Function (ESF) 8 Health and Medical Emergency Response Plan, a Health Alert Network (HAN) administrator and related duties, identification of emergency response roles, documentation of Incident Command System (ICS) trainings taken, exercises and evaluation of exercises.

Wisconsin Bad River Tribe (OPHPR)

Development of tribal infrastructure capacity such as: preparedness measures for prevention, detection, reporting, investigation, control, recovery, and improvement will be used as the guiding framework to further develop emergency ready public health departments. The performance measures will be used by local and tribal jurisdictions as a mechanism to evaluate the jurisdiction's capacity and capability to respond to terrorism, pandemic influenza, and other public health emergencies. Assessment and improvement of capabilities will be documented through functional exercise, full-scale exercise, or real event with Homeland Security Exercise and Evaluation Program (HSEEP) compliant after action reports and improvement plans.

AMERICAN RECOVERY AND REINVESTMENT ACT ACTIVITIES

Communities Putting Prevention to Work (NCCDPHP)

The Communities Putting Prevention to Work (CPPW) program is focused on producing sustainable, positive, and improved health outcomes via the promotion of policy, systems, and environmental-level change. CCPW-funded communities address tobacco control and obesity prevention through the implementation of multiple evidence-based MAPPS strategies - Media, Access, Point of Purchase/Promotion, Price, and Social Support and Services. When combined, MAPPS strategies can have a profound influence on improving health behaviors by changing community environments. Three CCPW-funded programs work with primarily with American Indian communities.

The Cherokee Nation is located across 14 counties in northeastern Oklahoma; over 122,000 members reside within the Tribal Jurisdictional Service Area. CPPW funds Cherokee Nation for both obesity and tobacco prevention. To tackle obesity, the Cherokee Nation is developing local media strategies that promote healthy food and beverage choices, adopting procurement and purchasing policies to reduce the price of healthy foods, implementing menu labeling, limiting unhealthy food and beverage availability in schools, and implementing farm-to-school programs; additional strategies focus on adopting quality physical education/activity in schools, afterschool, and childcare settings, increasing safe, attractive, and accessible places for physical activity, reducing the cost of recreation services, and expanding activity groups in workplaces, community gathering places, parks, and neighborhoods. To decrease tobacco use, the Cherokee Nation is implementing 24/7 tobacco-free policies in various sectors of the community including Cherokee Nation gaming operations, developing product placement guidelines for Cherokee Nation businesses and voluntary product placement programs for other merchants, supporting the elimination of free samples of tobacco and price discounts at Cherokee Nation businesses and events, and increasing access to cessation services for students and for patients of Cherokee Nation and area Indian Health Services.

The Great Lakes Inter-Tribal Council in north-central Wisconsin, funded by CCPW for tobacco prevention, is a consortium of 5 federally recognized American Indian tribes with a total tribal population of 9,371. Tobacco abuse prevention and control activities include: radio and television public service announcements, the development of an educational kit on traditional tobacco use, educational community gatherings, restriction of tobacco sales to minors, supporting 100% smoke-free workplaces (including casinos), posting warnings at retail outlets on reservations, encouraging retailers to place tobacco products out of sight, supporting the elimination of free tobacco product samples, encouraging tribes to use tobacco tax rebates for tobacco abuse prevention programs, supporting no rebates on tobacco sales to tribal members, hosting a Youth Retreat and Cultural Cessation Camp, and providing nicotine replacement therapies to tribal clinics.

The Pueblo of Jemez located in Sandoval County, New Mexico is a federally recognized tribe with approximately 3,400 members. CPPW funds the Jemez Pueblo for obesity prevention. Interventions focus on increasing the availability of healthy foods and decreasing the availability of unhealthy foods for children, and working with local growers to increase access to fresh fruits and vegetables. In addition, physical activity interventions are being developed to increase physical education classes for all grades and to expand physical activity opportunities for all members of the community.

OSTLTS awarded eight tribal health departments/bona fide agents cooperative agreements for the National Public Health Improvement Initiative totaling $2.5M. (Alaska Native Tribal Health Consortium; Cherokee Nation; Gila River Indian Community; Mille Lacs Band of Ojibwe; Montana-Wyoming Tribal Leaders Council; Navajo Nation Tribal Government, The Northwest Portland Area Indian Health Board; and SouthEast Alaska Regional Health Consortium). These tribes are part of mix of health departments including 49 states, 9 local, 5 territorial, and 3 freely associated pacific islands all focused on strengthening the nation's public health infrastructure and systematically increase performance management capacity to effectively and efficiently meet public health goals.

TRIBAL SUMMITS

National Indian Health Board and NIOSH, October 26, 2009

Meeting with the National Indian Health Board (NIHB) Franklin and members of the National Indian Health Board met to introduce themselves and have an opportunity to share information about NIHB and to meet NIOSH staff and learn about NIOSH's efforts related to AI/AN tribes was held in Atlanta, GA. Discussions on what NIHB was doing under their cooperative agreement with OMHD occurred. Follow-up Actions included schedule a meeting with TCUs to discuss occupations related to OSH and how students' may participate in CDCs minority summer programs. NIOSH shared information with educational partners from the TCUs to keep them aware of applicable internship opportunities.

EPA Region 5 Tribal Climate Change Symposium, December 1-3, 2009

The NCEH/ATSDR Tribal Liaison participated in the symposium, which was hosted by the Forest County Potawatomi Tribe in Wisconsin on and provided an overview regarding the environmental health effects of climate change and to convey current activities that NCEH is involved with. This meeting was an opportunity to conduct outreach about NCEH and ATSDR as well as the services of the NCEH/ATSDR Office of Tribal Affair

Quarterly Meetings of Joint Alaska Immunization Committee

Meeting attendees include ANTHC immunization program, State of Alaska Immunization Program, Public Health Nursing, Arctic Investigations Program. The meeting is held in Anchorage, AK. The intent of the meeting is to harmonize statewide immunization policy, vaccine handling procedures, data sharing and education of immunization program staff and the public

Quarterly Meetings: Alaska Area Specimen Bank Committee

Attendees include, ANTHC, Aleutian Pribilof Islands Association, Norton Sound Health Corporation, Bristol Bay Health Corp, Manilaaq Health Corporation, Southcentral Foundation, Arctic Slope Native Association, Yukon Kuskokwim Health Corporation, Southeast Alaska Regional Health Corporation, and the CDC/Arctic Investigations Program held at ANTHC, Anchorage, Alaska The purpose of the meeting has been to revise guidance for Specimen Bank and circulated for Tribal approval.

Quarterly Tribal Epidemiology Meetings (OSELS)

The first Quarterly Tribal Epidemiology Meeting (QTEM) for the 2009-2010 funding year was held on December 7, 2009 in Albuquerque, NM. The guest speaker was a former

US Surgeon General with the IHS. There were 15 participants at this meeting, including five staff from Albuquerque Area Southwest Tribal Epidemiology Center (AASTEC). During this meeting, it was decided that tribal youth tobacco would be the topic for the March QTEM. The second QTEM meeting was the 2009-2010 funding year was held on March 23, 2010 in Gallup, NM. There were 21 participants at this meeting from different Pueblos and the Navajo Nation. Unfortunately, however, no participants from AASTEC attended this meeting. The Tribal Epidemiologist continues working with the tribes to ensure the QTEM is addressing their data needs, and has committed to holding the meetings in different locations throughout the state. The third QTEM Meeting for the 2009-2010 funding year did not occur.

Quarterly Albuquerque Area Indian Health Board Executive Council Meetings

Albuquerque Area Indian Health Board Executive Council meetings were held during the 2009-2010 funding cycle at the time of New Mexico's continuation application/interim progress report submission in April, 2010. The Tribal Epidemiologist attended the December 18, 2009 Executive Council meetings where she provided an update of the work CHAP has been doing with communities and tribes. The Tribal Epidemiologist was unable to attend the March 9, 2010 Executive Council meeting due to a conflicting meeting with the NEC in Window Rock, AZ. She continues to attend and participate in the Executive Council meetings in Albuquerque as well as to submit her monthly work plan at the beginning of each month to NEC and AASTEC. These work plans are often incorporated into the meeting binders of tribal council voting members.

Agency Tribal Technical Advisory Group (OSTLTS)

CDC held two formal Tribal Consultation Advisory Committee (TCAC) meetings during FY 2010 along with regularly scheduled conference calls. The TCAC meeting was held January 26 to 28, 2010 in Atlanta GA and July 26 to 28, 2010 in Havre, Montana. The OD/Office for State, Tribal, Local and Territorial Support (OSTLTS)/Senior Tribal Liaisons worked in collaboration with the TCAC co-chairs and membership to develop substantive agendas. TCAC members provide an area report to inform and discuss public health issues affecting their tribe and other tribes in their area, and CDC provides a progress report on actions taken in response to TCAC recommendations.

Noted accomplishments include: created increased transparency about CDC budget so tribes can see resource allocations stratified by categorical areas of high priority to them; provided (at least annually) a technical assistance training by the Procurements and Grants Office to assist AI/AN stakeholders in competing for funding; established standardized language specifying tribal eligibility in all funding opportunity announcements; and monitored multiple programs such as those related to smoking, cancer, diabetes, and unintentional injuries to maintain and increase funding for Tribes as well as collect some AI/AN best practices.

The Tribal Consultation Session July 26 to 28, 2010 in Havre, Montana was hosted by the Ft. Belknap Indian Reservation and Chippewa-Cree Tribe of the Rocky Boy's Reservation of Montana. The meetings focused on resource allocations and budget priorities, public health preparedness and emergency response, epidemiology and disease surveillance, environmental public health in Indian Country, and obesity. CDC leadership listened to powerful tribal testimonies reflecting critical health needs present in many AI/AN communities and responded to specific questions asked by tribal leaders. These Consultation Sessions are helping CDC understand the scope and difficult realities tribal nations are facing. Consultations have provided opportunities for

meaningful dialogue between tribal leadership and CDC leadership resulting in new initiatives, programs, and collaborations to address public health needs while maintaining CDC's commitment to uphold the tenets of tribal consultation and to have a positive impact on the health of AI/AN people.

AGENCY TRIBAL CONSULTATION POLICY

Agency Tribal Consultation Policy

CDC/ATSDR Tribal Consultation Policy, General Administration CDC-115 was issued on October 18, 2005. The document establishes the CDC and ATSDR policy on consultation with American Indian and Alaska Native governments and tribal leaders and provides guidance for working effectively with IA/AN communities and organizations and enhancing IA/AN access to CDC programs. As an OPDIV within HHS, CDC's policy on tribal consultations will adhere to all provisions in the HHS Tribal Consultation policy revised January 2005.

CDC will honor the sovereignty of American Indian/Alaska Native governments, respect the inherent rights of self governance, commit to work on a government-to-government basis, and uphold the federal trust responsibility. Government-to-government consultation will be conducted with elected tribal officials or their designated representatives. The CDC will also confer with tribal and Alaska Native organizations and AI/AN urban and rural community before taking actions and/or making decisions that affect them. Consultation will include affected AI/AN governments and appropriate AI/AN organizations.

Although the federal-tribal government-to-government relationship encompasses federally recognized tribes, other statutes and policies exist that allow for consultation with non-federally recognized tribes and other AI/AN organizations that, by the nature of their business, serve AI/ AN people and might be negatively affected if excluded from the consultation process. In cases where the government-to-government relationship does not exist, as with programs in urban areas established to serve AI/ANs, state-recognized tribal groups, and other AI/AN organizations, HHS policy dictates that consultation take place to the extent that there is not a conflict-of-interest in stated federal statutes or authorizing language. However, if CDC wants to include organizations that do not represent a specific federally recognized tribal government on advisory committees or work groups, then Federal Advisory Committee Act (FACA) requirements must be followed.

This tribal consultation policy does not waive any tribal governmental rights, including treaty rights, sovereign immunities or jurisdiction; and nothing in the policy creates a right of action against CDC or HHS for failure to comply with the policy. Nothing in this policy waives the government's deliberative process privilege.

United States Department of Health and Human Services

Centers for Medicare and Medicaid Services (CMS)

The mission of CMS is to ensure effective, up-to-date health care coverage and to promote quality care for beneficiaries CMS' Vision, to achieve a transformed and modernized health care system, to ensure effective, up-to-date health care coverage and to promote quality care for beneficiaries. CMS will accomplish our mission by continuing to transform and modernize America's health care system. CMS' Strategic Action Plan Objectives Skilled, Committed, and Highly-Motivated Workforce Accurate and Predictable Payments High-Value Health Care Confident, Informed Consumers Collaborative Partnerships.

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Tribal Consultation Policy: CMS currently uses the guidance of the OS policy.
Tribal Consultation Workgroup Name: Tribal Technical Advisory Group (TTAG)
Website: http://www.cms.hhs.gov/

HIGHLIGHTS OF DIVISION SPECIFIC ACCOMPLISHMENTS/ACTIVITIES TARGETED TOWARD AMERICAN INDIANS/ALASKA NATIVES (AI/AN)

INCREASED STAFFING OF TRIBAL AFFAIRS GROUP

The Tribal Affairs Group (TAG) within the CMS Office of External Affairs and Beneficiary Services (OEABS) serves as the point of contact on Indian health issues for the agency. In 2010, the TAG increased its staff to 8 FTEs and tripled its operating budget. TAG provides ongoing and regular support to CMS components regarding Indian health implications, Tribal perspectives, and responds to external partners to other agencies in HHS, including IHS, national Indian organizations, and Tribes and Tribal organizations.

TRIBAL TECHNICAL ADVISORY GROUP

TAG provides administrative and policy support to the Tribal Technical Advisory Group (TTAG). The TTAG held three face-to-face meetings on November 2009, April 2010, and July 2010. The TTAG also holds monthly conference calls. The TAG developed an implementation plan to track priorities issues identified by the TTAG. Of the 32 priority issues identified by the TTAG, the TAG has been able to resolve 15 and are monitoring and working to resolve the more complicated issues, involving discontinuation of Medicaid optional services, behavioral health, long term care, ACA implementation, and ARRA Section 5006 implementation**.**

TTAG SUBCOMMITTEE ACCOMPLISHMENTS

The CMS TAG provides administrative and policy support to the TTAG subcommittees that meet by conference call on a weekly or bi-weekly basis. Meetings have discussed Data research and analysis, Long Term Care, Across State Borders, Outreach and Education, ACA implementation, ARRA policy implementation, Behavioral Health, and Budget/Strategic Planning. The subcommittees develop policy and program recommendations that are brought back to the TTAG membership as a whole for review and recommendations. The subcommittee work provides the Tribal expertise and analysis of many of the CMS issues, which are often complex and technical in nature.

CHIPRA NATIONAL ENROLLMENT CAMPAIGN AND GRANT SOLICITATION

On April 16, 2010, the CMS awarded $10 million in funding to 41 grantees to carry out outreach and enrollment activities for enrollment of AI/AN children in Medicaid and CHIP. The grants were awarded to the IHS, Tribes, Tribal organizations, and Urban Indian organizations under the authority of section 201 of CHIPRA. TAG staff, along with NACs, serves as project officers of these grants. TAG was instrumental in the development of the grant solicitation and awarding of the grants in a culturally appropriate manner. TAG has the lead role within CMS in the development of outreach materials for the enrollment of AI/AN children in Medicaid and CHIP including a public service announcement featuring Olympic gold medalist Billy Mills (Lakota Sioux), a CHIP video to support outreach activities, and culturally appropriate brochures and posters.

"CMS DAY" AT NATIONAL INDIAN HEALTH BOARD CONSUMER CONFERENCE

TAG directed the planning and implementation of "CMS Day" on September 22, 2010 at the NIHB annual conference. Workshop and plenary sessions were planned, in collaboration with TTAG and NIHB, to address topics of interest to Tribes. Plenary Sessions showcased Promising Practices in Outreach and Enrollment in Medicaid, CHIP, and Promising Practices in State/Tribal Consultation. Workshop sessions included a CMS American Indian and Alaskan Native Data Symposium, CMS related provisions in the Indian Health Care Improvement Act and the ACA, CHIP Grantees

shared experiences in Indian Country, Tribal State consultation and promising practices, screening and the prevention of cancer in Tribal communities, Across State Borders issues coordinating services for Medicaid beneficiaries, I/T/U Regional Extension Centers and HITECH, Long Term Care in Indian Country, and Medicare and Medicaid 101. The workshop sessions were collaborations between CMS, IHS, State, and Tribes.

MEDICINE DISH BROADCASTS

Medicine Dish broadcasts are held bi-monthly on a variety of CMS topics and are an important training tool for Indian health care professionals and administrators. These programs serve as a path to open communication, providing information and promoting discussion about Medicare, Medicaid and the CHIP and updates important to the health of American Indian and Alaska Native people. In 2010, the broadcasts featured: Urban Indian Health Programs, CHIPRA and ARRA Provisions, and CMS Electronic Health Record Incentive Programs.

TRAINING PROGRAMS IN IHS AREAS ON MEDICARE, MEDICAID AND CHIP

The CMS TAG, in collaboration through an Inter-Agency Agreement with the IHS, organized trainings in each of the 12 IHS geographic areas. The trainings are an example of the successful collaboration with the IHS to provide training opportunities to Tribal staff on CMS programs that would otherwise be unavailable in Indian country. The trainings provide an opportunity for individual discussions with CMS regional staff, State Medicaid, CHIP program directors, IHS, Tribal leaders and Tribal program staff. For 2010, there were more than 24 training sessions held with over 1500 participants.

ALL TRIBES CALLS

In collaboration with HHS' IGA, the CMS TAG sponsored a series of All Tribes' Calls; a bi-weekly teleconference, to obtain advice and input from Indian Country regarding CMS related provisions in the ACA. The calls featured such topics as new licensing provisions for Tribal health professionals and facilities in the Indian Health Care Improvement Act (IHCIA); impact of these requirements on Medicaid and Medicare participation; new or expanded home community based services and programs under Medicaid; provider and beneficiary enrollment; data reporting requirements from IHS to CMS; outreach and enrollment promising practices; and dissemination of information. Approximately, 80 participants are on each call and the summary of each call outlining major issues and questions are posted on the AI/AN Center on the CMS website.

TRIBAL DELEGATION MEETINGS

Boston Regional Office Medicaid Program – Region I

The Boston Regional Office (RO) Medicaid Program Branch continues to work with State Medicaid agencies with regard to the American Recovery and Reinvestment Act (ARRA) Section 5006 requirement for formal State Tribal consultation policies. RO staff conducted conference calls on the topic with Medicaid officials in each of the four New England States with Federally recognized Tribes. Issues addressed this year include: Tribal Federally Qualified Health Center (FQHC) payment in Rhode Island, Indian health provider licensing questions, Medicare Secondary Payer, End Stage Renal Disease (ESRD), Medicare-Like Rates (MLR) issues. Assistance with grants information, Health Information Technology for Economic and Clinical Health (HITECH) inquiries, Contract Health Services/Payer of last resort, and outreach and enrollment funding issues were also discussed.

Oneida Tribe Cost Reports - Region V

In July, CMS responded to the Oneida Tribe of Wisconsin Health Division's Business Director's request for assistance in deferring unfiled cost report debts from being referred to the Treasury Department's Collection Center, thereby allowing the Tribe to work through the cost report with their accounting department. The CMS contacted NGS, whom assured CMS that they will not refer the Tribe's debt to the United States Department of Treasury.

Proposed Termination of Mescalero Family Center – Dialysis Facility, Mescalero, New Mexico - Region VI

On June 10, 2010, the New Mexico Department of Health completed a recertification survey of the Mescalero Family Center which is a dialysis facility owned by the Mescalero Apache Tribe, during which the State surveyors identified Immediate Jeopardy (IJ) related to the Center's failure to complete the required monthly water system microbiological monitoring for more than a year. The patients were transferred to another facility until Mescalero was able to get culture and Endotoxin results demonstrating these systems were safe. The IJ was abated and the facility was placed on a ninety day termination with non-compliance in nine Conditions of Coverage. CMS staff worked with the Mescalero Apache Tribe to implement an interim agreement to allow the facility to be operational.

Policy Guidance to Nebraska HHS on Multiple Encounters - Region VII, VIII

Region VII and Region VIII NACs held a conference call with DMCHO staff and the Nebraska State Medicaid Agency to discuss the state's current Medicaid payment methodology for Tribal and Indian Health Service facilities and CMS' recent guidance allowing States to pay for multiple encounters per day. Nebraska State Medicaid staff expressed concerns regarding Medicaid Management Information Systems (MMIS) and the cost to change the system to allow for payments for multiple encounters. Region VII and VIII NACs reminded the State Agency about the 100% federal medical assistance percentage (FMAP) and the enhanced FMAP for MMIS.

Memorandum of Understanding Between the Ponca Tribe (CHIPRA Grantee) and Nebraska HHS - Region VII

The NAC facilitated a conference call between the Ponca Tribe and Nebraska Medicaid to discuss CHIPRA grant requirements, Ponca's project, and the need for technical assistance and data sharing. The Nebraska Medicaid provided training and signed a Memorandum of Understanding (MOU) providing the Ponca Tribe access to the state's application database (NFocus), baseline and quarterly data, as well as a point of contact at the State Agency to discuss eligibility/application status.

AI/AN CHIPRA Grants Status - Region VII

Region VII NAC served as a facilitator for a CHIPRA grant review panel. The NAC serves as the Project Officer for two CHIP grantees in Region VII and facilitated the panel discussion on scores, proposal's strengths and weaknesses and prepared a final report for Central Office. A total of nine grants were reviewed and scored.

North Dakota Pharmacy Reconciliation Process - Region VIII

The CMS Regional Staff worked with IHS pharmacy staff, and the North Dakota Medicaid Agency to reconcile fee-for-service (FFS) pharmacy claims to the All-Inclusive-Rate (AIR). This involved extensive review of the CMS-64 Quarterly Expense Report, and pharmacy claims by the Regional Financial Management and IHS pharmacy staff.

The review showed additional payments due to the IHS pharmacy in the final reconciliation with the AIR. The State has paid some of the reconciliation amounts with the remaining reconciliation still due to the IHS pharmacy.

Colorado and Utah CHIP MCOs Compliance with ARRA - Region VIII

During the CMS/IHS trainings, it was brought to the attention of CMS staff that the CHIP Managed Care Organizations (MCOs) were requiring I/T/Us to enroll in their provider network to receive reimbursement. CMS staff provided training to and worked with both States to come into compliance with ARRA Section 5006(d).

Colorado Submits State Plan for Multiple Visits - Region VIII

Colorado Tribes had expressed interest in receiving reimbursement for multiple encounters per day for a client. Regional staff worked with the Medicaid Agency to submit a State Plan amendment to detail the change. The amendment clarifies that the State makes payments for multiple visit/encounter claims for different types of services provided to a client on the same date of service by the same Indian health facility when the services provided are different or are for different diagnosis codes. State Plan Amendment approved and effective August 11, 2010.

Arizona Provider Certification Process - Region IX

As part of its annual Tribal provider certification process for Medicaid participation, the Arizona Health Care Cost Containment System (AHCCCS) sends the RO the provider certifications for review and approval. The RO recently reviewed this process with input from the CMS Division of Survey and Certification, the CMS Office of External Affairs staff, AHCCCS staff and the Tribes. This input resulted in CMS modifying the letter used for its review of these Tribal provider documents. Starting in August 2010, the language in the CMS letter indicates that CMS has received a copy of the attestation that the Tribal provider has provided AHCCCS indicating the provider meets AHCCCS' requirements to participate in Medicaid. Using this modified letter, CMS and AHCCCS will continue the current Tribal provider certification process.

AI/AN Traditional Healing Services Coverage - Region IX

On September 8, 2010, CMS Region IX queried the CMS NACs on which of their States cover traditional healing services. This request was generated initially by a provider outside of our region who was interested in whether Arizona covered any traditional healing services. The Arizona Department of Health Services responded that traditional healing services have not been eliminated from the subvention covered services but the subvention funding was cut significantly. AHCCCS is now interested in how many States cover this service nationally.

Washington Tribe Approved as Eligibility Site - Region X

The Port Gamble S'Klallam Tribe in Seattle requested the State's assistance in being able to make eligibility determinations for both Medicaid and Food Stamps in 1999. This year, that request was finally achieved with approved plan amendments to CMS and United States Department of Agriculture. The Tribe has reported that they are having much greater success than they had anticipated in finding eligible beneficiaries and presented their efforts at the 2010 National Indian Health Board meeting in Sioux Falls.

Medicaid Administrative Matching - Region X

All four States in Region X have agreements with Federally recognized Tribes for administrative claiming under their Medicaid program. Only Washington has sought approval of a unique Tribal claiming plan, which was submitted in 2006. CMS has continued to allow the State to make payments based on the existing plan while concurrently working with the State and Tribes to resolve continuing concerns regarding statistical validity. Alaska, Oregon, and Idaho continue to operate their programs under existing agreements. The CMS, TTAG, and the State have renewed efforts to resolve the on-going concerns. Washington is continuing to work on drafting an approval plan.

FQHC Re-certification Issues - Region X

Several Tribes in the Portland Area needed to be recertified as FQHCs this year for Medicare billing. The Regional NAC assisted the Lower Elwha Klallam Tribe, the Coeur d'Alene Tribe, and Siletz in this process. It is expected that this new requirement will continue to raise questions and issues pending completion of the Medicare Administrative Contractors (MAC) transitions.

MLR Issue Resolution - Region X

Tribes and hospitals continue to raise questions about the applicability of MLR and the methodologies used to determine payments for CHS. The majority of Tribes in Region X are self governed and in the Portland IHS Area, there are no IHS hospitals. These two conditions create additional challenges in implementation of MLR. First, there is possibly greater referral of outpatient services to non-IHS hospitals, which in another area might have been referred in an IHS hospital; and second, since there are no free software or other resources for outpatient claims recalculation, Tribes are employing a variety of strategies to re-price claims. Therefore, hospitals that are receiving reimbursements from multiple Tribes are confused by the different methodologies. The NAC continues to provide information to hospitals and Tribal CHS programs.

Washington Bridge Waiver Tribal Meeting - Region X

Washington State submitted an 1115 ACA waiver to create expanded Medicaid eligibility for some populations below 133% of the Federal Poverty Level (FPL). The State's proposal is to build on three existing State-funded programs and pull individuals with incomes below 133% FPL into the Medicaid waiver population. The State's design is dependent on maintaining the existing structure of the State-funded programs, which would include a waiver of some of the premium and cost-sharing provisions found in Section 5006 of ARRA. CMS conducted a meeting with the Washington State Tribes to understand the issues and the implications from the Tribes directly. The State has addressed the cost sharing issue to be in compliance with ARRA 5006(a) requirements. Issues are still being discussed regarding managed care arrangements, payment rates, and payment methodologies.

Idaho Outstation Locations - Region X

The Coeur d'Alene Tribe (CDA) requested CMS assistance in working with the State to resolve issues following the State elimination of outstation workers. CMS worked with the State, the CDA Tribe, the Idaho State Tribal group, and the Nez Perce Tribe in understanding the Federal requirements and reaching an amicable agreement within the State's budgetary concerns While the agreement has been reached and is being implemented with two of the five Tribes in Idaho, CMS will continue to monitor compliance with the Outstation Location requirements.

Technical Assistance Consultation - Region X

Technical assistance sessions were provided to Idaho, Oregon, and Alaska. While these States have submitted their Medicaid State Plan Amendments (SPAs), there are on-going issues with implementation and existing authorities.

Washington Behavioral Health - Region X

Washington provides Medicaid behavioral health services primarily through a waiver – the exception are AI/AN served within Indian Health facilities. Due to a change in State law that went into effect July 1, 2010, many of the providers employed by Indian health programs were no longer eligible to provide services and consequently receive reimbursement. The State has proposed a strategy to address the issue with Tribes. The State and the Tribes are continuing to work on resolution.

PACE Review for Cherokee Elder Care, Oklahoma

The DMCHO and Division of Medicare Health Plan Operations (DMHPO) worked jointly with the State to perform an operational review of Cherokee Elder Care, Oklahoma's first PACE program. The review yielded no findings, and the review team provided technical guidance in the continued delivery of service to eligible seniors.

Home Health Care Certification

The NAC met with representatives from the Port Gamble S'Klallam Tribe, Washington State Department of Social and Health Services (DSHS) and Department of Health (DOH) regarding barriers to participation as a home health care provider due to certification requirements and structure. The jurisdictional authorities have resulted in a barrier to Tribes being able to participate in these programs. The State, Tribes and CMS are working to identify needed changes in state law and revised practices to facilitate Tribal participation in home health, hospice and other programs that require a state survey or license for receipt of reimbursements.

State-Tribal Mental Health Workgroups in Washington

At the request of Tribes and the State, the Region X NAC participated in on-going roundtable discussions on Mental Health delivery and compliance issues. Washington State's mental health services, with the exception of services provided by Tribes to AI/ANs, are covered through a managed care waiver. The State has increasingly become aware of differences in services, provider qualifications, and medical necessity in Tribal facilities and is working on strengthening evaluation and compliance with Federal and State requirements.

Fred LeRoy Health & Wellness Center (Ponca Tribe) Staff Training

The NAC conducted training for the Clinic's staff at their Omaha site and via video conference to their Lincoln and Norfolk office. The training focused on Open Enrollment and plan finder updates.

Regional Staff and Consortium Administrator meet with clinic staff, Flandreau Santee Sioux Tribe

The Medicaid Consortium Administrator and CMS staff met with IHS Staff at the Flandreau Santee Sioux Tribe. Staff at the facility provided a tour of the clinic and other facilities. CMS staff discussed Medicaid, CHIP, services and billing issues.

DATA Symposium

On July 30, 2010, the TAG, in collaboration with one of our Tribal partners, California Regional Indian Health Board (CRIHB), sponsored a Data Symposium to better understand existing reports and identify the need for further data analysis. CRIHB presented the findings from the Data Symposium at the NIHB Annual Consumer Conference and is in the process of producing a Medicine Dish broadcast on the Symposium findings and updates.

Direct Service Tribes Meeting

TAG and the CMS Lead NAC participated in a panel presentation with IHS Headquarters staff persons and the Billings Area Executive Officer in a session focused on Third Party Revenue Enhancement at the Direct Service Tribes national meeting.

2010 Tribal Self Governance Annual Conference - Region IX

On May 2–6, 2010, the National Tribal Self-Governance Conference was held in Scottsdale, Arizona. The CMS Region IX NAC staffed the exhibit which drew close to three hundred visitors to answer questions on CMS programs posed by Tribal leaders, Executive Directors, CEOs, and other healthcare professionals.

12th Annual Indian Health Service National Partnership Conference - Region IX

On March 24, 2010, the CMS RO NAC presented on Medicare and Indian Health at the IHS Partnership Conference held in Nashville, Tennessee. An emphasis was placed on enrolling in all CMS programs. There were 41 breakout sessions and conference attendance was estimated to be close to 600.

Phoenix IHS/Tribes/Urban Meeting - Region IX

On May 27, 2010, the CMS NAC presented at the Inter-Tribal Council of Arizona Tribal Leaders Steering Committee and the IHS/Office of Self-Determination I/T/U Meeting held in Phoenix. The audience was comprised of Tribal leaders and health directors from Arizona, Nevada and Utah and an estimated 50 people were in attendance.

2010 CMS Region IX Outreach & Education Training - Region IX

The CMS, IHS, and Tribal Representatives coordinated training sessions for Indian health providers on CMS programs. In FY2010, CMS Region IX training sessions were held in Navajo Nation, Sacramento, Tucson, San Diego, Phoenix, Reno and Utah.

5th Annual Nevada Urban Indians, Inc. Diabetes Health Fair - Region IX

On March 27, 2010, the CMS NAC exhibited at the event to promote CMS diabetes and preventive service. The health fair was held in Reno, Nevada.

Sacramento Native American Health Center - Region IX

On March 30, 2010, the CMS NAC attended a face-to-face meeting with Indian Elders and the Benefits Navigator for the Sacramento Native American Health Center to discuss Medicare Part D. Most had excellent drug coverage through a Federal Employee Health Benefits (FEHB) plan, previous employment and VA coverage. It was suggested that Elders discuss their options first with their health plan before changing to another plan.

California Consortium for Urban Indian Health - Region IX

On April 23, 2010, the CMS NAC presented on CMS programs at the California Urban Indian Health Conference held in Sacramento, CA. The conference was organized by the California Consortium for Urban Indian Health. Presenters included representatives

from the California Rural Indian Health Board, IHS, California HHS, and the Indian Health Program. Sacramento Mayor Kevin Johnson and Senator Barbara Boxer received awards for their assistance to Indian people.

San Diego American Indian Health Center - Region IX

On June 14, 2010, the NAC discussed resources and training with the Program Development Director at the San Diego American Indian Health Center. The Director had created a new outreach position to assist American Indians to enroll in Medicare, Medicaid and CHIP programs. We discussed CMS online resources, grants, local resources, NAC availability and the upcoming CMS/IHS I/T/U Program training on August 4-5, 2010 in San Diego.

The CMS and California State Monthly Call - Region IX

The CMS RO has been holding monthly state calls with Department of Health Care Services and State Indian Health Programs to discuss new, pending or follow-up Tribal concerns and to provide updates.

Self Governance Annual Meeting - Region X

The Region X NAC provided helped staff a booth at the 22nd Self Governance Conference in Arizona with the Region X NAC. This provided an opportunity to interact with over 200 Tribal Leaders to explain how CMS programs and services can advance and support decisions regarding self governance.

NIHB Annual Consumer Conference

CMS TAG Director participated in a panel presentation with other HHS Operating Divisions at the NIHB Annual Consumer Conference on collaboration of Indian health issues within the Department.

Meetings with American Indian Community House Representatives - Region II

The American Indian Community House is an urban American Indian organization that provides services to Native Americans residing in New York City. The Regional NAC has had meetings with American Indian Community House representatives to discuss their concerns and technical assistance which included a better understanding of Medicare and Medicaid. One issue of particular concern is clarification of Tribal documentation needed for American Indians to access Medicaid services.

Cross Border Medicaid Payment Issues - Region II

The St. Regis Mohawk Tribe operates Partridge House Treatment Program which is an inpatient substance abuse facility on their reservation in Hogansville, New York. The clinic has been in operation since 1983 and is licensed by the State of New York. Partridge House is unique as compared to other non-Tribal treatment facilities because it provides culturally sensitive treatment, along with other accepted treatment practices. Partridge House accepts and provides treatment to American Indians/Alaskan Natives (AI/AN) from anywhere in the United States who qualify for their program.

REGIONAL VISITS TO TRIBES

State-Tribal Meetings

The NAC participated in at least half of the regularly scheduled meetings with Federally recognized Tribes and State Health and Social Service representatives in Washington, Oregon, and Idaho. The NAC participated in one such meeting in Alaska. These meetings provide a forum for State and Tribes to identify current and potential issues; provide input on interpretation of Federal and State statutory changes, including suggestions for implementation; and maintain a regular consistent relationship between the States and Tribes. The NAC participation allows for an opportunity to share updated information regarding Medicare, Medicaid and CHIP, and to maintain Tribal contacts.

HHS Meeting with Ho Chunk District Representatives - Region V

On June 14, 2010, the CMS Region V NAC participated in a meeting with the Regional Director (***Cristal Thomas***) and the Ho-chunk nation in Wisconsin. The purpose of the meeting was to share information on CMS programs/Tribal resources, grants, provide technical assistance and answer questions. Issues discussed include: reconciliation of their past and current FQHC Medicare cost reports

Meeting with the Heart of America Indian Center - Region VII

The NAC and the ***HHS Regional Director*** met with the Executive Director of the Heart of America Indian Center (HAIC) to discuss Kansas City Urban Indian issues, access to health and social services, and barriers to obtaining Tribal enrollment cards and Certificate of Degree of Indian Blood (CDIBs). The NAC facilitated meetings between the HAIC Executive Director and Kickapoo and Prairie Band Potawatomi Tribal Leaders and there end result was the Kickapoo Health Director offering to provide transportation to HAIC clients for health and/or social services appointments at the Kickapoo Clinic.

American Indian Council Meeting - Region VII

A meeting was held with the American Indian Council (AIC) to discuss health issues and needsof the AI/AN urban community in the Kansas City metro area. The lack of culturally sensitive Medicaid/CHIP outreach to the Urban American Indian community and of knowledge on the ACA and its impact on Urban American Indians were among the issues brought forward by the AIC. The AIC shared data and stories/testimonials to illustrate the significant need for an Urban American Indian Clinic in the Kansas City metro area. AIC agreed to put the information presented in a report that will be shared by the NAC with the Oklahoma Area IHS. The NAC provided the AIC AI/AN Medicare, Medicaid and Children's Health Insurance Program (CHIP) outreach materials as well as copies of the Medicare and the New Health Care Law publication.

Kansas State Tribes Meeting - Region VII

On July 28, 2010, the NAC participated in a Kansas State Tribal meeting facilitated by the ***HHS Regional Director***. The meeting included the participation of Tribal Leaders from the Prairie Band Potawatomi Nation and Kickapoo Tribes, Four Tribal Women's Wellness Coalition Board, Kansas Department of Health and Environment Secretary, University of Kansas Medical Center, and the IHS Area Office. Among the topics discussed were Medicare group payer option for Parts B and D and the ACA. The NAC sent via e-mail additional information to the Prairie Band Potawatomi Chairman and Health Director on the requirements to enter into a Part B Formal Group Payer Agreement with CMS. Also, the NAC shared information on best practices, specifically the Fond du Lac Medicare Part D Program Case Study, "Strategies for Tribes to

Increase Pharmacy Reimbursements from the Medicare Part D Prescription Drug Benefit."

Quarterly Tribal Health Directors Meeting, Indian Township, Maine, May 20, 2010

The CMS NAC attended the meeting of Tribal health directors and other Tribal health representatives from the five federally recognized Tribes in Maine. Representatives of the State Medicaid agency (MaineCare Services) and ***HHS Regional Director*** and staff also attended the meeting. The NAC provided information regarding CMS topics including ARRA requirements for State Tribal consultation and exemptions from cost sharing and premiums for Native Americans. The CMS RO continues to work with Maine and with the Tribes when technical assistance is requested.

In-Service for Native American Elder Health, April 13, 2010

A representative of the Region I CMS Medicaid program branch attended the meeting at Massachusetts Executive Office of Elder Affairs offices in Boston. The program was presented by the Senior Medicare Patrol (SMP) Integration Project.

Wisconsin Department of Health Services and Wisconsin Indian Tribes Mid-Year Consultation Meeting - June 16, 2010

The CMS Region V State Lead participated in the Wisconsin Department of Health Services (DHS) and the Wisconsin Indian Tribes Mid-Year Consultation Meeting in Green Bay, Wisconsin on June 16, 2010. During the meeting DHS completed the Status of Deliverable section on their November 2009-June 2010 Consultation Implementation Plan. The Plan summarized DHS and the Tribe's progress in addressing the issues agreed upon at the November 2009 consultation meeting.

White Cloud Health Station

On April 14th, White Cloud Health Station Acting Director, Kelly Battese, conducted an on-site Resource and Patient Management System (RPMS) demo for CMS Region VII and KHPA staff.

California IHS Tribal Leaders Conference – March 9-11, 2010

On March 9-11, 2010 CMS regional/central office leadership and the NAC attended the California IHS Tribal Leaders Conference in Cabazon, California. The California Tribes had 46 significant issues that were brought up, most resulting from the California Medi-Cal optional benefit cuts. March 10th was devoted to California State Medicaid Program issues, and March 11th was geared to HHS/CMS concerns.

American Diabetes Association Expo

On April 24, 2010, the CMS Region IX NAC and the Medicaid expert exhibited at the American Diabetes Association Diabetes Expo. The CMS exhibit drew close to 400 visitors asking CMS program question. The ADA Diabetes Expo arranged a cultural section which included Native Health, Gila River Health Care, Navajo Special Diabetes Project of Window Rock, Inter-Tribal Council of Arizona, Ak-Chin Diabetes Program, Hispanic Organizations, and the National Association of Hispanic Nurses-Valle del Sol Chapter.

Northwest Portland Area Indian Health Board (NPAIHB)

The NAC participated in two of the Northwest Portland Area Indian Health Board (NPAIHB) quarterly board meetings and Health Director Meetings and presented on Medicare provider enrollment, the CMS/IHS Memorandum of Understanding (MOU), the

IHS facility list, equitable relief and Medicare Part B, and outreach efforts for enrolling eligible individuals in Medicare, Medicaid, and CHIP. During FY 2010, the NAC visited the Lower Elwha Klallam Tribe, the Squaxin Island Tribe, Puyallup, Suquamish, Tulalip, Colville, Coeur d'Alene, Fort Hall, Cow Creek, Squaxin Island, Cook Inlet, Southcentral Foundation, Alaska Native Medical Center, Nez Perce, and Kalispel Tribe. Topics discussed during these meetings varied depending on the interest and need of the individual Tribe.

HITECH Roundtable

TAG, in conjunction with the April TTAG face-to-face meeting, sponsored a HITECH Roundtable that brought together CMS, IHS, and Tribal experts to examine how the HITECH incentive programs will impact the Indian health delivery system and major issues and barriers that need to be addressed. Some of the recommendation and findings include: provide information on HITECH training opportunities to ITUs; look into the possibility of counting patients without third party payers toward the Medicaid incentive threshold; develop solicitations concerning the EHR readiness assessments and training; report back on which ITUs actually receive incentives.

Kickapoo Health Fair - Region VII

The NAC, in partnership with the Kansas Health Policy Authority, exhibited at this annual fair. Medicare, Medicaid and CHIP enrollment, resources and general information were shared with attendees.

TRIBAL SUMMITS

Training for Tribes in the IHS Nashville North Area – Region II

This was the first time that the region has been split and had two separate Indian Health Service (IHS) Area trainings. Training for the Nashville North Area was a two-day training held August 12-13, 2010 at the Seneca Niagara Hotel in Niagara Falls, New York. Region II was the principal organizer and IHS moderated the training. Topics included an overview of Health Care Reform by the Regional Director of Region II (Dr. Jaime Torres), other presentations included Medicare 101 and Medicare Updates, Medicaid and CHIP 101, CHIPRA & ARRA, and CMS resources all presented by CMS Regional and Central Office staff, Behavioral Health Care and Substance Abuse presented by SAMSHA, Medicaid eligibility presented by New York City Department of Health, Social Security updates by a Social Security Administration (SSA) representative via phone and Electronic Health Records & Meaningful Use presented by IHS.

CMS Participates in IHS Area Office Training for CA Tribes

On January 21-22, 2010, the CMS NAC attended the California Area IHS' two-day training on CHS, Catastrophic Health Emergency Fund and MLR which is calculated by Indian Health designated personnel. CMS clarified policy and reimbursement concerns regarding the MLR and the CMS protocol for handling Section 506 Medicare Modernization Act (MMA) non-compliance violations at the CMS RO level, required documentation, timeframe for processing and contacts with the hospital administrator to obtain documentation for review. The regulation outlines the requirement that Medicare-participating hospitals must accept no more than a MLR from the Indian health programs as payment in full.

Part D Training - Region X

The Region X NAC organized Medicare Part D enrollment training session for Tribes. Tribal representatives from all four Region X States attended. Presentations included overviews of Medicare in general, the Medicare Part D benefit, using the plan finder, and Social Security benefits. There was also planned time for sharing enrollment strategies that are used by the Tribes. Region X will host a longer event in FY 2011 and will request the IRS to participate with as many of the questions that came up in FY 2010 that pertained to tax liabilities for Tribal assistance in enrollment.

Colville Training - Region X

IHS is the primary provider of health care services in this area. The Tribe has contracted for behavioral health and community health and has implemented two tribally operated clinics with funding from IHS and Health Resources and Services Administration (HRSA) in 2 communities. CMS regularly receives questions from the Tribe, referral sources, IHS, and HRSA regarding the differences in the requirements due to the different funding streams and/or administrative structure. At the request of the Tribal Council, the NAC arranged a training session that included the IHS, the Tribal health programs, the board for the HRSA funded sites, HRSA, and the State to clarify the similarities and differences between the Federal programs, and the Federal requirements under HRSA, IHS, and CMS, and to facilitate communication at the local level. About 25 were in attendance representing all of the entities.

Training for Tribes in IHS Nashville Area South - Region IV

Training was held in Hollywood, Florida for the Tribes in the Nashville IHS Area South on July 28-29, 2010, which included for the first time an opportunity for the Tribes to participate by WebEx. It was a two-day session which included an overview of Medicare, Medicaid, including a discussion of 1915(c) and 1115 waivers; CHIPRA and ARRA and their impact on AI/AN; Cross Border issues; and Survey and Certification.

The training was attended by representatives of four out of the six Tribes in Region IV.

Tribal representatives attending the training sessions and CMS/IHS staff agreed that there is a need to hold more training/meetings that include IHS, CMS, Tribes and States.

The CMS/IHS Bemidji Strategy Session January 20, 2010 - Region V

On January 20, 2010, the Region V Regional Administrator of the Division of Medicaid and Children's Health Operations (DMCHO) and the Region V NAC met with the Deputy Director of the IHS Bemidji Area office. The purpose of this meeting was to discuss the upcoming CMS/IHS area trainings and conduct a pilot project in the State of Michigan to increase education, enrollment and reimbursement of Tribes in CMS programs.

The CMS/IHS Training for Tribes in Michigan, Minnesota and Wisconsin - Region V

The CMS and IHS worked together to provide state-specific Tribal training in June, July and August for the Tribes in Michigan, Minnesota and Wisconsin. Tribal feedback was used to develop the agendas for each training session and topics covered included: ARRA and CHIPRA updates, State Medicaid activities, Medicare program updates and a CMS/IHS overview of the HITECH Act.

The CMS/IHS Training for Tribes in Oklahoma - Region VI

The CMS Co-NACs worked with the Oklahoma City IHS Area Office Business Office Coordinator and the Oklahoma City Area Inter-Tribal Health Board to coordinate the training session for the Oklahoma Tribes. The training was held August 3-4, 2010 at the Postal Center in Norman, Oklahoma. Topics covered included the overview of Medicare

and Medicaid, Sooner Care/CHIP, HITECH, the ACA, new enrollment periods, and Trailblazer claims. Three CMS RO staff attended and made presentations. There were 56 individuals in attendance each day.

The CMS/IHS Training for Tribes in New Mexico - Region VI

The CMS Co-NACs worked with the Albuquerque IHS Area Office Business Office Coordinator to coordinate the training session for the New Mexico Tribes. The training was held August 9-10, 2010 at the Hard Rock Hotel & Casino in Isleta, New Mexico. Topics covered included the Affordable Care Act (ACA), CMS' role in Indian Country, Medicare 101, Tribal Technical Advisory Group (TTAG) Update, CHIP 101, CHIPRA, ARRA, HITECH, Medicaid 101, and Fee for Service/Eligibility. Two CMS RO staff attended and made presentations.132 was in attendance on the first day and attendees 96 were on the second day.

Kansas Health Policy Authority Indian Health Training - Region VII

The NAC, in collaboration with the Oklahoma Area IHS, conducted training for Kansas Health Policy Authority (KHPA), Kansas Department of Social & Rehabilitation Services (SRS), Kansas Department of Health & Environment, and Kansas Department on Aging staff on Indian Health and CMS' Role in AI/AN Healthcare. The training also included a discussion on the Indian specific provisions in ARRA and CHIPRA. A meeting with KHPA and SRS Mental Health staff followed the training to discuss enrollment of Indian health providers in Medicaid managed care organizations.

EMTALA Training for Aberdeen Area IHS and Tribal Facilities - Region VII

The Region VII NAC collaborated with the Denver RO Survey & Enforcement Branch and Kansas City RO Division of Quality Improvement (QI) and conducted training of the Emergency Medical Treatment and Active Labor Act (EMTALA) for Aberdeen Area IHS and Tribal facilities. The training was held on June 1, 2010 at the Marina Inn Conference Center in South Sioux City, Nebraska. Forty-seven people attended the one-day training which included the participation of IHS Aberdeen Area and IHS QI staff, Chief Executive Officers (CEOs), Director of Nursing and Chief Medical Officers.

The CMS/IHS Aberdeen & Oklahoma Area Training - Region VII

The CMS/IHS training session for Region VII Indian Health Service/Tribal/Urban Programs (I/T/U) was held on August 17-18, 2010 at the Prairie Band Potawatomi Casino & Resort. Agencies that participated include the Department of Veterans Affairs (VA), SSA, the Nebraska HHS, Kansas Health Policy Authority, Iowa Medicaid Enterprise, and Sooner Care Oklahoma. Medicare and Medicaid 101, Medicare Prescription Drug Plan Finder, MLR, HITECH, CHIPRA, ARRA, and the ACA were among the topics presented to approximately 45 attendees. The HHS Regional Director joined the training on day two and provided a live demo of the HHS Portal.

The CMS and IHS Area Training Sessions - Region VIII

The CMS staff worked with IHS and Tribal staff to develop training sessions in the following IHS Areas: Aberdeen, Phoenix, Billings and Albuquerque. Topics covered at all of trainings included Medicaid and CHIP 101, Provider Enrollment for CMS Programs, and statutory changes from the CHIPRA and the ARRA. State-specific information about Medicaid/CHIP programs was presented by each State Medicaid Agency's staff. The SSA and VA also presented at the trainings. Approximately 40 to 50 people attended each of the training sessions.

IHS Area Training Sessions in Anchorage and Seattle - Region X

The NAC worked with the Alaska Native Health Consortium and the Northwest Portland Area Indian Health Board to develop training sessions in Anchorage, Alaska; Fairbanks, Alaska; Pocatello, Idaho; Spokane, Washington; and Seattle, Washington. Sessions provided training for staff at Tribal and IHS sites in Alaska, Washington, Idaho, and Oregon. State staff from all four States also attended and presented at the sessions. Topics covered included Medicare 101, Medicaid and CHIP 101, Medicaid and Medicare Compliance Audits, Telemedicine, Medicaid Mental Health Issues and Billing, Pharmacy Billing, Outreach and Enrollment Strategies, Medicaid Provider Enrollment, ARRA provisions, CHS and CMS Coordination, FQHC Cost Reports, and MLR. Approximately 224 individuals participated.

United States Department of Health and Human Services

Food and Drug Administration (FDA)

The FDA is responsible for protecting the public health by assuring the safety, efficacy, and security of human and veterinary drugs, biological products, medical devices, our nation's food supply, cosmetics, and products that emit radiation. The FDA is also responsible for advancing the public health by helping to speed innovations that make medicines and foods more effective, safer, and more affordable; and helping the public get the accurate, science based information they need to use medicines and foods to improve their health.

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HIGHLIGHTS OF DIVISION SPECIFIC ACCOMPLISHMENTS/ACTIVITIES TARGETED TOWARD AMERICAN INDIANS/ALASKA NATIVES (AI/AN)

Health Promotion and Disease Prevention

On March 27, 2010, FDA's San Francisco District Office's Public Affairs Specialist spoke at 33rd Annual California Conference on American Indian Education, in Santa Clara. The PAS presented information to 400 participants on dietary supplements and fraud entitled "Watch Your Health: Labels, Supplements and Fraud." The PAS talked about the signs of health fraud, regulating dietary supplements and allowable claims, supplement interaction with prescription medicine, and seeking information from health professionals. A portion of the presentation included an interactive segment on reading the food label. The PAS exhibited and promoted various FDA materials.

In May 2010, FDA's Office of Women's Health (OWH) participated in the National Indian Health Board's Public Health Summit. In Albuquerque, NM. More than 200 participants, vendors and exhibitors participated in this event. The Summit brought together Tribal leaders, federal representatives, and public health professionals from across Indian Country. Attendees gained information on a various programs occurring in Indian Country. These programs promote disease prevention, support tribal community-based research, and build public health capacity. The programs also help reduce the disease burden of American Indians and Alaska Natives.

Health Professions Recruitment

OWH participated in the 2010 Nurse Leaders in Native Care Conference**,** July 19-23, 2010 in Washington, D.C. More than 200 public health professionals **attended.** This annual conference provides an opportunity for nurse professionals to network with peers and colleagues on nursing topics of common concern, update knowledge, competence, and performance in current nursing and health care trends and issues. OWH amplified nursing practice to its fullest potential by improving patient outcomes through innovative, collaborative, and best practices rooted in the profession.

FDA's Office of Equal Employment Opportunity and Diversity Management (OEEODM) sponsored one student intern from the American University's Washington Internships for Native Students (WINS) in 2010. Participating students gained professional work experience from interning at FDA. The student took courses that focused on Native American policy and engaged in social and cultural extra-curricular events sponsored by the American University.

OEEODM worked with the Association of American Indian Physicians' Native American Youth Initiative to sponsor a forum for 70 students in 2010. The goal was to share information on career opportunities at FDA.

OEEODM interacted with the Society of American Indian Government Employees (SAIGE) to expand outreach and to increase Native American candidates for entry, mid- and senior-level positions at FDA. The mission of SAIGE is to promote recruiting, retaining, developing and advancing American Indian and Alaska Native government employees.

TRIBAL DELEGATION MEETINGS

Mohegan Tribe

In 2010, the FDA Northeast Region's Retail Food Specialist provided technical assistance to the Mohegan and the Mashantucket Pequot tribal health departments located in Connecticut. The technical assistance focused on Food Code interpretation, retail food safety, reduced oxygen packaging of food, food establishment plan review and compliance issues. In 2010, FDA provided ongoing standardization to both tribal health authorities Retail Food Safety Inspection Officers. This initiative includes inspector training and auditing. The regional office also supported to the Mohegan Tribe's Voluntary National Retail Food Regulatory Program Standards. With assistance from the Regional Food Specialist, the Mohegan Tribal health department initiated a foodborne illness risk \survey based on FDA's national, multi-year surveys on foodborne illness incidents and risk factors at retail. FDA supported the Mehegan tribal health department to achieve two standards of the FDA Voluntary National Retail Food Regulatory Program Standards.

Mashantucket Pequot Tribe

In 2010, the FDA Northeast Region's Retail Food Specialist provided technical assistance to the Mashantucket Pequot tribal health department located in Connecticut. The technical assistance focused on Food Code interpretation, retail food safety, reduced oxygen packaging of food, food establishment plan review and compliance issues. The regional office provided standardization to the tribal health authority's Retail Food Safety Inspection Officers. This initiative includes inspector training and auditing. The regional office also supported the Mashantucket Tribes Voluntary National Retail Food Regulatory Program Standards.

Lac du Flambeau Band of Lake Superior Chippewa Tribe

The Lac du Flambeau Tribe participated in the FDA Voluntary Program Standards Initiative from 2008 to 2010. This voluntary initiative offers continuous improvements toward gold standards recognized as the necessary building blocks for an effective and efficient Food Safety Program. The Tribe enrolled in the program in 2008, completed their Retail Food Program self-assessment in 2009 and is conducting a baseline survey of their established inventory in 2010.

Tuscarora Tribe: In November 2010, FDA's New York District Office participated in a program with the Tuscarora Tribe. District held at the Tuscarora Indian Reservation Senior Center in Lewiston, New York. FDA's Public Affairs Specialist provided information on food safety, hand washing and tips to prevent foodborne illness during the holidays. Tribal members also learned about recalls, seafood safety and weather emergencies.

Seneca Manufacturing Company and Skookum Creek Tobacco Company: In December 2010, CTP hosted a Stakeholder Discussion session for tobacco product manufacturers and growers, in which representatives from two tribal-owned tobacco product manufacturing companies participated – Seneca Manufacturing Company and Skookum Creek Tobacco Company.

Squaxin Island Tribe: In November 2010 CTP met with members of the Squaxin Island Tribe (Washington State), as a Tribe and as representatives of Skookum Creek Tobacco Company. The purpose of the meeting was to discuss enforcement of the Family Smoking Prevention and Tobacco Control Act.

TRIBAL SUMMITS

National Congress of American Indians

On December 1, 2010, CTP met with the National Congress of American Indians to exchange information on missions, explore collaborations and to discuss the Family Smoking Prevention and Tobacco Control Act and various CTP events that have an impact on American Indian and Alaska Natives. CTP staff discussed the tobacco statute, outreach strategies to American Indians and Alaska Native Tribes, the proposed FDA Stakeholder Discussion Series and CTP compliance and enforcement initiatives.

Detroit Federal Executive Board Diversity Committee Orientation

In November 2010, ten FDA Detroit District Office managers and investigative staff attended a presentation to increase awareness of cultural background of Native American Tribes and the impact of federal and state statutes on tribal communities.

National Native Commercial Tobacco Abuse Prevention Network

In November 2010, CTP met with staff from the National Native Commercial Tobacco Abuse Prevention Network to learn more about the organization and discuss the Center's Stakeholder Discussion series.

SUMMARY OF 2010 REGIONAL CONSULTATION SESSIONS

In July 2010, the Food and Drug Administration's (FDA) Center for Tobacco Products (CTP) participated in the Centers for Disease Control and Prevention 5th Biannual Tribal Consultation Session in Havre, Montana. The Ft. Belknap Indian Reservation and Chippewa-Cree Tribe of the Rocky Boy's Reservation of Montana hosted the consultation.

In September 2010, CTP convened an internal American Indian Stakeholder Work Group. In September 2010, CTP staff attended a Tribal Consultation course at Duke University. The course is designed for federal and tribal agency officials to develop a greater understanding and awareness of the legal relationship that exists between the U.S. Government and federally recognized Indian tribes.

United States Department of Health and Human Services

Health Resources and Services Administration (HRSA)

The Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services, is the primary federal agency for improving access to health care services for people who are uninsured, isolated, or medically vulnerable. Comprising 6 bureaus and 13 offices, HRSA provides leadership and financial support to health care providers in every state and U.S. territory. HRSA grantees provide health care to uninsured people, people living with HIV/AIDS, and pregnant women, mothers and children. They train health professionals and improve systems of care in rural communities. HRSA oversees organ, bone marrow, and cord blood donation. It supports programs that prepare against bioterrorism, compensate individuals harmed by vaccination, and maintains databases that protect against health care malpractice and health care waste, fraud and abuse.

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HIGHLIGHTS OF DIVISION SPECIFIC ACCOMPLISHMENTS/ACTIVITIES TARGETED TOWARD AMERICAN INDIANS/ALASKA NATIVES (AI/AN)

IHS and HRSA Collaborations

Under the leadership of Dr. Mary Wakefield and Dr. Yvette Roubideaux, HRSA Administrator and IHS Director, respectively, have engaged in a series of meetings to strengthen cross-agency collaborations and provide better support to AI/AN communities. Several priorities common to both IHS and HRSA have been identified including: reducing the burden of disease on the AI/AN populations; increasing health professional workforce development; increasing health information technology investments in Tribal and Urban health facilities; and improving access to funding and grant opportunities. Meetings were held on February 23, May 17, and November 4, 2010. Letters to Tribal and Urban Indian leadership were developed and signed by Dr. Wakefield and Dr. Roubideaux. The letters address the increased need for AI/AN representation on federal advisory committees; providing better support around the recruitment and retention of healthcare providers; and increasing access to care.

ACF and HRSA Tribal Maternal, Infant, and Early Childhood Home Visiting Program

Three million dollars in grants to Indian Tribes, Tribal Organizations, or Urban Indian Organizations were recently awarded for fiscal year (FY) 2010 under the Tribal Maternal, Infant, and Early Childhood Home Visiting Grant Program. The program is a collaboration between HRSA and the ACF that will support successful implementation of high quality, culturally relevant home visiting programs that have demonstrated evidence of effectiveness in Tribal settings. These home visiting services provided under this grant are meant to improve child and family outcomes focusing on areas such as prenatal, infant, maternal, and child health and development, parenting skills, school readiness, and family socio-economic status, and reduce incidence of child abuse and neglect, injuries, crime, and domestic violence. ACF and HRSA also envision that this program will help to support and strengthen cooperation and coordination among various programs such as American Indian/Alaska Native Head Start, Tribal childcare, IHS clinical programs, and Indian child welfare.

HRSA Webpage and Internet Links

HRSA developed an Indian Health webpage in an effort to share information about various HRSA programs, Health Professional Shortage Areas, Medically Underserved Populations, as well as HRSA regional staff contact information. In an effort to increase communication with AI/AN communities HRSA, in collaboration with IHS, has posted the "Find a Health Center" widget on the IHS homepage. The widget allows a user to enter a zip code to locate the nearest of more than 7,900 service delivery sites nationwide that provide preventive and primary care to 19 million patients. About 40 percent of patients at the community health centers (CHC) have no health insurance and CHCs will treat persons regardless of ability to pay and any charges for service are set according to income.

DIVISION SPECIFIC ACTIVITIES

HIV Care and Services in Alaska

The Alaska Native Tribal Health Consortium (ANTHC) Ryan White Early Intervention Services (EIS) program was funded under Part C of the Ryan White Care Act in FY 2010 at $487,500. ANTHC provides and/or coordinates comprehensive preventive and primary care services through a complex delivery of HIV care and treatment, case management, referrals to primary care services, and consultative support for primary

care providers who serve rural Alaska as well as the AI/AN population. ANTHC also provides a full spectrum of primary and specialty medical care, behavioral health, dental, lab, and pharmacy services for the Native beneficiary population (the majority of ANTHC EIS patients served) and referrals for non-beneficiaries as needed. The EIS clinical team provides on-site care and case management to approximately 20 non-beneficiaries of the Tribal Health System at the Interior Community Health Center in Fairbanks. Anchorage Neighborhood Health Center, the other Part C program in Alaska, serves primarily the Anchorage urban area. Two other AIDS Service Organizations provide Part B, HIV/AIDS Drug Assistance services to all Alaskans: Alaskan AIDS Assistance Association (4A's) and Interior AIDS Association (IAA). IAA provides services for the Fairbanks area and 4 A's serves the rest of the state.

Joint IHS/HRSA Tribal letters

To date, two letters have been developed jointly and signed by the HRSA Administrator and the IHS Director. The letters were developed to address concerns raised by Tribal and Urban Indian leadership at a recent White House Tribal Nations Conference and again at the 12th Annual Budget Consultation. A second "Dear Tribal Leader" letter highlighting implementation efforts around the Affordable Care Act and the reauthorization of the Indian Health Care Improvement Act is in the clearance process.

AI/AN Representation in HPSA Negotiated Rulemaking Process

HRSA recently formed a new committee to recommend the methodology and criteria for the designation of Medically Underserved Populations (MUPs) and Health Professional Shortage Areas (HPSAs) using a Negotiated Rulemaking process. The goal is that this committee of technical experts and stakeholders will reach consensus on a new rule. There are two **T**ribal organization representatives on the committee, one from the National Council of Urban Indian Health (NCUIH) and the other representing the National Indian Health Board (NIHB). There is also a representative of IHS on the HHS workgroup that will receive the recommendations, participate in the meetings, and be the primary IHS contact as the negotiations proceed. In addition, a representative of the Alaska Department of Health is serving on the committee to represent the unique challenges of the extreme frontier areas and the Alaska Native populations.

HRSA Supports a Minority Faculty Fellowship Program

Northern Arizona University (NAU) is a recipient of funds for a Minority Faculty Fellowship Program (MFFP) focused on the AI/AN population. Its faculty development program operates through the Dental Hygiene and Health Sciences program. A successful Native American MFFP graduate currently holds an assistant professor position in the Health Sciences program and volunteers as a mentor for the current fellow in the program. This mentorship has provided significant insight to the current fellow, a member of the Lakota tribe, who has over 30 years experience with the IHS, and is very active in the Native American community in Northern Arizona. MFFP fellows have been instrumental in providing community service projects to the NAU students on reservations. For example, an MFFP fellow has coordinated the Ottens' Dental Hygiene Hopi Health Care project, which successfully integrated dental hygiene services on the Hopi reservation. This project provided oral health education and dental hygiene services to American Indians, by rotating dental hygiene students to the Hopi Dental Clinic on a regular basis. It also provided an opportunity to recruit Hopi young people into the NAU health professions.

Capacity Development for AI/AN Serving Health Care Providers

In FY 2009 and 2010 HRSA funded eight of its AIDS Education and Training Centers (AETC) working across 37 states to enhance their efforts targeted to AI/AN populations. Funds are to promote HIV testing, and provide training, consultation, technical assistance, and capacity building activities. This program builds on lessons learned from previous Minority AIDS Initiative (MAI) funded AI/AN capacity building projects. The goals of the AI/AN targeted AETCs include: 1) to strengthen Native American organizations to implement or enhance HIV testing, screening, and care and treatment programs; 2) to increase the number of IHS, Tribal, Urban and other AI/AN serving clinicians who routinely perform HIV risk assessments, screening, testing, diagnosis and treatment in AI/AN populations; 3) to reduce the rate of new HIV infections of AI/ANs in the United States and; 4) to reduce the percentage of AIDS diagnoses when first testing positive for HIV infection within AI/AN communities. Funding in Fiscal Year 2009 for this program was $854,377; FY 2010 funding was $742,000.

The AETCs target AI/AN health care providers to increase capacity of clinicians to more effectively test, treat, and link the underserved HIV AI/AN population to care. In addition, HRSA's HIV/AIDS Bureau is collaborating with IHS (through an operational Memorandum of Understanding) to implement the IHS National HIV Universal Screening Initiative. The AETCs serve as the primary trainers of administrators and clinicians to assist with implementation of the Initiative which implements the Center for Disease Control and Prevention's (CDC) 2006 HIV Testing Recommendations in targeted IHS, Tribal, and Urban sites throughout the country. HRSA and IHS are planning to coordinate and conduct training programs on-site at IHS-funded facilities, Tribal and Urban sites, and other Native-serving facilities across the U.S. The initiative will train clinicians, as well as Community Health Aides (CHAs), Community Health Practitioners (CHPs), and Community Health Representatives (CHRs) to provide high quality HIV services to AI/AN patients. In addition, the initiative assists in establishing linkages to care for newly identified HIV-infected patients and establishes an effective co-management model of HIV care including development of appropriate tools.

National Health Service Corps and IHS Facilities

IHS and HRSA's Bureau of Clinician Recruitment and Service (BCRS) staff have met on an ongoing basis to collaborate on outreach and placement of NHSC clinicians at IHS sites. Outreach strategies include increased communications to explain and define the benefits of participation in the National Health Service Corp (NHSC) and possible placements in IHS-supported facilities. NHSC and IHS will be developing a joint fact sheet highlighting the opportunities and linkages between the current programs for use in outreach to prospective clinicians and sites. IHS participated in the August 2010 NHSC Scholar Placement Conference and highlighted sites that were approved NHSC sites for clinicians looking for site placement opportunities. Since May 2010, two new Tribal sites have been approved, seven applications are pending, and two new applications were received on November 3, 2010. Currently, there are 111 NHSC participants serving in IHS-supported facilities.

State Title V Maternal and Child Health Block Grant Program Efforts

In July 2010, states submitted the findings of their 5-year needs assessments to HRSA. HRSA plans to review and compile the priority needs identified by State Maternal and Child Health programs as part of an effort to determine national priorities and to facilitate informed decision-making. A search of the priority needs identified in the state 2010 needs assessments using the Title V Information System (TVIS) indicates that

approximately 40 percent of the State Title V programs identified a priority need which addressed disparities in health outcomes among maternal and child health populations. Two states (Michigan and North Dakota) identified a priority need that specifically addressed American Indian populations.
-Michigan – Reduce African American and American Indian infant mortality rates.
-North Dakota – Form and strengthen partnerships with families, American Indians, and underserved populations.

A search in TVIS of the state performance measures established by states in follow-up to their 2010 Needs Assessments showed that two states had developed a State Performance Measure, which specifically addressed the needs of their American Indian populations.

- North Dakota: The degree to which families and American Indians participate in Title V program and policy activities.
- Washington: Decrease the rate of infant mortality among the Native American population.

While not a requirement, some states opt to establish a State Outcome Measure in addition to the six National Outcome Measures. Based on the 2010 Needs Assessments, the following State Outcome Measures were developed to target the specific needs of the American Indian populations.

- Michigan: Ratio of Native American infant mortality to the white infant mortality rate.
- Montana: Native American Infant Mortality Rate.
- North Dakota: The ratio of the American Indian infant mortality rate to the white infant mortality rate.
- South Dakota: American Indian infant mortality rate per 1,000 live births.

Increase in HRSA Grant Reviewers

During the summer of 2010, HRSA Administrator, Dr. Wakefield sent a letter to "Friends of HRSA" to invite them to consider becoming a HRSA Grant Reviewer. This essential role helps to ensure that high quality grants are awarded. Each grant program accepts competitive applications, which must be reviewed by an outside panel of experts to ensure objectivity. To best evaluate the viability of grant applications, experts are needed from a wide variety of professions, work settings, and cultural backgrounds. Since June 15, 2010, HRSA has had the pleasure of adding 31 reviewers that identified themselves as AI/AN into the HRSA Electronic Handbook.

Technical Assistance Workshops

Throughout the summer of 2010, HRSA's Office of Rural Health Policy (ORHP) provided Tribal technical assistance workshops that focused primarily on ORHP funding opportunities and grant writing. On June 30, 2010, ORHP held a workshop in North Dakota that hosted approximately 30-40 Tribal organizations. In addition, the Bureau of Primary Health Care (BPHC) has tentatively scheduled a pilot training for IHS and HRSA grantees in January regarding the BPHC Uniform Data System (UDS) for Resource and Patient Management System (RPMS) users in Alaska. The training will be held in conjunction with the Alaska Primary Care Association.

Text4baby

HRSA's Maternal and Child Health Bureau (MCHB), Office of Women's Health is a lead partner in the Text4baby initiative, a free mobile information service to promote healthy birth outcomes and reduce infant mortality among underserved populations. This initiative is implemented through a broad, public-private partnership including government and Tribal agencies, corporations, academic institutions, professional associations, and non-profit organizations. Outreach efforts for the Text4baby initiative include messages targeted to the Native American population through posters and other materials featuring a Native American woman.

AI/AN Children's Health Included in Chartbook

In response to concerns that AI/AN children are not adequately represented in the National Survey of Children's Health, the HRSA Maternal and Child Health Bureau (MCHB) collaborated with the IHS Maternal and Child Health Program to create a supplement Chartbook targeting AI/AN children. Working with "Dine' for Our Children," an integrated services Navajo Nation grantee, the effort resulted in 550 face-to-face interviews using the National Survey of Children with Special Health Care Needs. The survey results are not yet available.

HRSA will continue the collaboration with IHS to disseminate the results from the supplemental survey on AI/AN children's health. Data will be included in a chartbook highlighting overall survey findings in 2010 with follow-up plans to publish in-depth statistical analyses of selected topics in AI/AN child health for publication in peer-reviewed journals. The survey is statistically 'weighted' to account for households without phones, and future efforts are planned to contact cell-phone only households to account for the rapid increase in the percent of cell-phone only households.

MCH Certificate Program

Currently, the University of Arizona has a graduate certificate program in Maternal and Child Health (MCH) Epidemiology. This program is a university-community partnership for graduate training in maternal and child health. Working with the IHS, the United South and Eastern Tribes, Inc.; county and indigenous population representatives representing Appalachian Kentucky, the University of Arizona Zuckerman College of Public Health, and the University of Kentucky College of Public Health have designed a 15-credit graduate certificate course aimed at increasing the capacity in MCH epidemiology of MCH workers serving in rural, isolated, and underserved IHS regions and Appalachian counties.

Emergency Medical Services for Children

Through an Inter-Agency Agreement, HRSA and the IHS have worked collaboratively to increase access to Emergency Medical Services for Children (EMSC) in underserved populations, including AI/ANs. In FY 2010, the project was funded at $275,000. In addition, the EMSC program provided "Culture Cards" to be distributed to health care providers serving AI/AN communities. This program will support cultural awareness training to non-Tribal EMS systems that transport IHS patients. Targeted Technical Assistance will be provided to build new EMS programs for Tribal communities. This program will assist in facilitating the procurement of ambulances and appropriate pediatric equipment for Tribal EMSC programs. Program activities include providing pediatric specific pre-hospital and out-of-hospital training to eligible IHS affiliated EMS programs, and promoting relationships between Tribal/IHS EMS programs and HRSA EMSC grantees relevant to pediatric emergencies and pre-hospital care. Lastly, this

collaboration has developed and utilizes an external stakeholder's workgroup/advisory committee that promotes a sustained relationship with Tribal and Urban Indian leaders. The EMSC Partnership for Children Stakeholders group includes IHS staff.

Healthy Start

In FY 2010, HRSA provided approximately $3.6 million for Healthy Start grants to eliminate or reduce the factors associated with infant mortality and other adverse infant and maternal health outcomes. Three of the Healthy Start grantees are Tribal Organizations and two others have a prominent Tribal presence. The three Tribal organizations include: Great Plains Tribal Chairman's Health Board in Rapid City, South Dakota; Inter-Tribal Council, Inc., in Sault Ste Marie, Michigan; and Great Lakes Inter-Tribal in Lac Du Flambeau, Wisconsin. The city of Minneapolis, Minnesota, and the Department of Health in Pembroke, North Carolina, represent the current organizations with a "prominent Tribal presence" or projects that serve a large population of American Indians. Those projects have found it helpful, if not necessary, to develop health education materials, health plans, and other programmatic materials specifically tailored to the American Indian population.

Summer Institute: Indians into Medicine

The North Dakota Area Health Education Center (AHEC) worked with the University of North Dakota, School of Medicine's Indians into Medicine Program to enhance their Summer Institute experience. A wellness and nutrition program was developed for 89 American Indian students from four states and was designed to assist the students to learn how to make healthy food choices based on the food available on their Reservations. Students also learned the importance of teamwork through a variety of experiences, and that exercise is important in maintaining a healthy balance.

Center of Excellence

The University of Montana's Center of Excellence (COE) program, funded by HRSA's Bureau of Health Professions, aims to increase the number of Native American students entering and graduating in the universities' pharmacy program as well as facilitating recruitment, retention, and educational preparation of the students. The program enrolled 12 Native American students to aid in the recruitment and retention of Native Americans in the pharmacy profession. The COE is linked to the Missoula Indian Center (MIC), which promotes health, education, and general welfare of Urban Native Americans living in and around the Missoula area; MIC serves about 1,500 clients at any one time. The MIC provides information and serves as a support system to the Native American community by networking with local health and human service agencies to provide maximum resources. The MIC also helps bridge the gap when clients relocate from reservations to urban life by functioning as the primary communication center for the needs associated with this transition.

Arizona Area Health Education Center Inter-Professional Education

The Arizona Area Health Education Center (AHEC) program has been working over the past four years to establish inter-professional education of health care students across many disciplines. The HRSA AHEC-funded Visionary and Innovative Health Sciences Training in Arizona (VIHSTA) project engages faculty in medicine, nursing, pharmacy, public health, social work, dental health, and other primary care disciplines to work with multidisciplinary students in community-based teams. Students, residents, and community health workers experience service-learning training at American Indian Tribal sites, such as Chinle on the Navajo (Dine') Reservation, and in Nogales on the U.S.-

Mexico border. Approximately 66 students have now experienced team training through VIHSTA including students from Northern Arizona University, Arizona State University, and the University of Arizona.

Health Information Technology

HRSA's Office of Rural Health Policy is currently developing a rural network Health Information Technology (HIT) program working with the National Organization State Offices of Rural Health (SORH) to engage Tribal organizations in their states on this funding opportunity. The SORHs are pleased to be a part of this activity and a webinar will be held specifically for Tribes around the funding opportunity and grant writing.

Health Occupations for Today and Tomorrow

South Dakota SORH recently collaborated with three hospitals (Sanford Mid-Dakota Medical Center, Coteau Des Prairies Hospital in Sisseton, and Wagner Community Memorial Hospital) to expand their Health Occupations for Today & Tomorrow program into Tribal schools. These three hospitals are providing information on a variety of healthcare careers to Native American students of all ages through hands-on activities. The goal is to promote healthcare careers to Native American students in an effort to interest them in pursuing careers in the healthcare industry. Each facility received $6,000 for a total of $18,000 in SORH funding.

Rural Health Outreach Grantees

HRSA's Office of Rural Health Policy's Rural Health Care Services Outreach Grant Program encourages the development of new and innovative health care delivery systems in rural communities that lack essential health care services. The emphasis of this grant program is on service delivery through collaboration, requiring the lead applicant organization to form a consortium with at least two additional partners. The community being served must be involved in the development and ongoing operations of the program, to appropriately address the needs of the population. Programs funded have varied greatly and have brought care that would not otherwise have been available to at least two million rural citizens across the country. Through consortia of local providers and others, rural communities have managed to provide services such as hospice, dental care for children, and prenatal care in many remote areas.

In FY 2010, three organizations received funding awards through this program:

- Hardrock Council on Substance Abuse, Inc. in Kykotsmovi Village, Arizona, has been funded since May 2009. This project created the Hardrock Youth Leadership Program which serves as resource to youth and a mentor for fellow peers. The mental/behavioral health component of the program aims to increase the number of contacts per case and to provide youth mental health services and referrals with an emphasis on family wellness and counseling.
- Lake County Tribal Health, Inc. (LCTHC) in Lakeport, California, has been funded since May 2009. The project offers comprehensive services in a socially and physically reassuring setting accepted by the Native American population by expanding LCTHC's trusted and successful Big Valley Preschool/Parenting Center to create the Native Communities Cultural Wellness Center designed by the target population.
- Wishek Hospital Clinic Association in Wishek, North Dakota, has been funded since May 2009. This project is a "Three Share" insurance coverage program, which

includes a wellness component. Business, employee, and community sources contribute to cost of insurance for mostly Tribal communities.

RPMS and UDS Training

For the past 3 years, HRSA's BPHC has had an Inter-Agency Agreement (IAA) with the IHS funded at $50,000 annually to update the IHS RPMS with the BPHC Uniform Data System (UDS) requirements. This funding will assist in the integration of the IHS and HRSA data sets. In addition, training on UDS reporting in RPMS is planned for winter 2011 for joint IHS and HRSA grantees that use the RPMS system. Training curriculum is currently in development with input from IHS and grantees. BPHC has tentatively scheduled a pilot training for IHS and HRSA grantees in January 2011 in Alaska. The training will be held in conjunction with the Alaska Primary Care Association.

TRIBAL DELEGATION MEETINGS

Twelfth Annual National HHS Tribal Budget and Policy Consultation

HRSA participated in the HHS Tribal Budget and Policy Consultation with a presentation on the Resource Day. The Office of Health Equity presented information on HRSA programs of interest during the HHS Tribal Budget and Policy Resource Day during a session with sister agencies including the National Institute of Health, The Children and Families Administration, Centers for Disease Control and Prevention, and the Substance Abuse and Mental Health Administration.

The HRSA Administrator, Dr. Mary Wakefield, Deputy Administrator, Dr. Marcia Brand, and Acting Director, Office of Health Equity, Dr. Deborah Willis-Fillinger received testimony on behalf of HRSA throughout the budget testimony sessions. HRSA also received testimony from several Tribal leaders that included Tribal Elders and elected officials representing the National Indian Health Board (NIHB), the National Council on Urban Indian Health (NCUIH), the San Carlos Apache Tribe, the Oglala Sioux Tribe, the Sault Ste Marie Tribe of Chippewa Indians, and the Fallon Paiute Shoshone Tribe. The testimony received was shared with HRSA's AI/AN intra-agency workgroup and has been incorporated into strategies to provide comprehensive, culturally acceptable, accessible, high quality, and affordable health care to Tribal and Urban Indian populations.

NCUIH Annual Leadership Conference

On April 7, 2010, HRSA leadership participated at the NCUIH Annual Leadership Conference and HRSA staff provided targeted information to urban organizations through a "HRSA 101" presentation on "Understanding HRSA programs and designations." This presentation included topics such as how to become a health center, obtain a HPSA designation, become a NHSC clinician, and write a competitive grant application.

HHS Region V Tribal Consultation

The Chicago Region V, Office of Regional Operations (ORO), participated in the HHS Regional Consultation Meeting on April 20, 2010, in Bloomington, Minnesota. Dr. Wakefield provided welcoming remarks on behalf of Secretary Sebelius. Issues discussed at the meeting included: recommendations for improvement in the consultation and reporting processes, needs for increased access to direct federal funding for health programs, support to improve grant application writing capabilities, access to childhood obesity prevention programs, information about the applicability of

the Affordable Care Act, additional funding for health information technology, and greater collaboration between other agencies and the IHS. A Regional Implementation Plan designed to address Tribal priorities and recommendations was developed by the Regional Director's Office.

Region VIII Workgroup

Dallas Regional staff participated in an initial workgroup meeting that focused on challenges encountered by tribes in Region VIII, such as substance abuse, unemployment, suicide, and domestic violence. Leadership and staff attended the meeting from the HHS Operating Division, Department of Education, and Colorado Commission of Indian Affairs, as well as an American Indian Colorado State Senator. Each attendee contributed agency-specific program information relevant to Tribal challenges. To address some of these challenges HRSA's next step includes meeting with the Indian Caucus of the National Conference of State Legislators to obtain additional information about Tribal disparities. The workgroup will develop recommendations for the Secretary of HHS.

Council for Confederated Tribes of Colville, Washington

The Seattle Region X, ORO, participated in the May 19, 2010, Council for the Confederated Tribes of Colville, Washington, training and information workshop. This workshop was facilitated by the Native American Coordinator at the Centers for Medicare and Medicaid Services. The large, geographically isolated, Reservation has two joint-funded (IHS and CHC) clinics, an IHS managed clinic and a Tribal 638 clinic. The goal of the workshop was to promote uniformity in how each Tribal health entity on the reservation is engaging in Medicaid and Medicare billing and accessing resource assistance programs. The workshop audience included the Tribal Council, key Tribal administrators, and health care staff. This activity was well received and is seen as an excellent example of cross agency collaboration in support of a complex Tribal health system.

NIHB 2nd Annual Public Health Summit

Dr. Brand, Deputy Administrator for HRSA, attended the NIHB's 2nd Annual Public Health Summit in Albuquerque, New Mexico, on May 19, 2010.

Association of American Indian Physicians National Native American Youth Initiative

Within HRSA's Bureau of Health Professions (BHPr), the Division of Student Loans and Scholarships (DSLS) has begun working with the Association of American Indian Physicians to begin identifying barriers that Tribal schools have in applying for BHPr scholarships and loans. DSLS sought support from the Bureau of Clinician Recruitment and Services to deliver a presentation to students at the Association of American Indian National Native American Youth Initiative meeting in June 2010.

ORO and Bemidji Area Leaders

On June 29, 2010, the Operations Director of the Chicago Region V, ORO, met with IHS Bemidji-Area leaders. Participants discussed recommendations to: update the needs assessment of the Area's Tribal populations; improve communications with the Tribal leaders and health directors; increase Tribal members receiving services at CHCs; improve recruitment of primary care providers to IHS facilities; and the need to reduce the rate of infant mortality in Tribal communities. Information shared included a potential HRSA grant-writing workshop, the Patient Safety and Clinical Pharmacy Services Collaborative (PSPC), and the Home Visiting Program. Following the meeting, IHS sent

all Tribal contacts the most current information from HRSA concerning the grant writing workshop, PSPC, and the home visiting program grant announcement. In August, a follow up meeting occurred between staff to discuss primary care provider recruitment and the NHSC. Tribal leaders and health center directors will continue to be informed of opportunities to participate as the HRSA Healthy Weight Collaborative evolves.

ORO, Seattle Office, created a Region X Tribal Health Board Distribution List that transmits information and alerts about HRSA announcements and grant opportunities, including those from other HHS OPDIVs such as the HHS Office of Minority Health. Most recently, ORO Seattle recently transmitted the link to the press release announcing the availability of funds to support the Prevention Center for Healthy Weight (also known as the Healthy Weight Collaborative).

Region IX Primary Care Workshop

On June 24, 2010, the ORO Region IX Office in San Francisco hosted a Primary Care Workshop for Arizona American Indian Communities and received very positive feedback. This workshop provided information, training, and assistance to Tribal entities regarding HRSA resources and programs, especially CHC support and workforce development. Other partners include the Arizona Department of Health Services-Bureau of Health Systems Development, Arizona Health Care Cost Containment System, and the Inter-Tribal Council of Arizona. In response to requests for a similar training in Nevada, the HRSA Region IX office planned a one-day workshop for Nevada and Rural Communities held in Reno, Nevada, on September 23, 2010. Partners included the Great Basin Primary Care Association, Nevada State Primary Care Office, SORH, and Nevada Indian Health Board. ORO San Francisco hosted 35-40 participants from Nevada and Western California Tribes.

IHS Urban Executive Directors and Chief Executive Officers

On July 7, 2010, HRSA participated on the Urban Executive Director/Chief Executive Officer conference call to provide an update on HRSA's activities. HRSA staff provided information regarding the technical assistance workshop held in Denver, Colorado, CHC funding announcements and application due dates, as well as the status of the MUP/HPSA workgroup. The audience was comprised of executive directors of 34 Urban Indian health programs, 11 IHS area urban coordinators, and four staff persons from the Office of Urban Indian Health Program.

Fourteenth Annual United Tribes Technical College Tribal Leaders Summit

The Denver Regional Office Director participated on September 9, 2010, at the 14th Annual United Tribes Technical College Tribal Leaders Summit on a health issues panel discussion with other health experts. At the Summit, HRSA discussed health workforce, the Home Visiting Program, and other AI/AN health related areas. This annual gathering provided HRSA with an opportunity to meet Tribal leaders from around the region to exchange information about current issues.

NIHB Twenty-Seventh Annual Consumer Conference

The HRSA Administrator, Dr. Wakefield, along with the IHS Director, Dr. Roubideaux, and the SAMHSA Administrator, Ms. Hyde, participated on a panel on September 21, 2010, at the 27th Annual Consumer Conference hosted by NIHB. This annual conference took place in Sioux Falls, South Dakota. The theme of the conference was "Tribal-State Relations and American Indian and Alaska Native Health Care." The HHS

senior leaders focused their discussion on updating the participants on their respective agency's activities related to the AI/AN community.

National Congress of American Indians

On November 15, 2010, RADM Don Weaver represented HRSA at the National Congress of American Indians conference in Albuquerque, New Mexico.

American Recovery and Reinvestment Act Activities Specific to Tribes

The HRSA's Bureau of Primary Health Care had the opportunity to provide several dual-funded (HRSA and Tribal/Urban Indian) health care facilities with American Recovery and Reinvestment Act funding, totaling $12,843,916 to Tribal Organizations and $18,467,865 to Urban Indian Organizations. Twenty-six organizations received both Health Center Program and IHS funding (19 dually-funded Tribal organizations as well as seven dually-funded Section 330 and Urban Indian Program organizations).

AGNECY TRIBAL ADVISORY GROUP INFORMATION

HRSA AI/AN Workgroup

Although HRSA does not have a Tribal Advisory Group, HRSA is currently exploring the best ways to engage the AI/AN community. The HRSA Office of Health Equity has completed an environmental scan of other HHS agency Tribal Advisory Committees and will be making recommendations to the HRSA leadership. An All Tribal/Urban Consultation and Stakeholders meeting is planned for FY 2011 that will further inform the structure and function of a HRSA Tribal Advisory Committee. Other ongoing HRSA activities include:

- HRSA has re-established a Tribal Workgroup with representatives from each bureau and office that inform senior leadership of activities, challenges, and opportunities for AI/AN entities.
- HRSA has been fortunate to have Native American representation to actively participate on the CDC/HRSA Advisory Committee for HIV and STD Prevention for the past several years.
- HRSA and IHS are working together to increase the number of AI/AN representatives on a number of HRSA's Advisory Committees. IHS has provided names of potential candidates to HRSA's bureaus and offices. HRSA is in the process of sending eligible candidates forward through the appropriate channels for selection.

AFFORDABLE CARE ACT ACTIVITES SPECIFIC TO TRIBES

IHCIA and NHSC

HRSA's Bureau of Clinician Recruitment and Service (BCRS) has worked with IHS to implement two key provisions of the Indian Health Care Improvement Act (IHCIA), that relate to the NHSC, in order to strengthen recruitment opportunities for Tribal sites. Indian Health programs will now be able to utilize NHSC clinicians assigned to Indian Health programs to provide services only to Tribal members, with the exception of responding to emergency medical needs. BCRS is in the process of redesigning its Site Application to enable Tribal sites to elect this new designation. BCRS has also implemented an additional provision of IHCIA as part of the FY 2011 NHSC Loan Repayment Program Guidance. This provision will allow NHSC applicants who intend to practice at Tribally managed/compacted or Urban Indian Health Program facilities to be eligible to provide services if they have a current, full, permanent, unencumbered,

unrestricted health professional license, certificate or registration (whichever is applicable) from any State.

Preventive Medicine Residency Program

The Affordable Care Act expanded eligible entities for funding to include Tribal health departments with accredited preventive medicine residency programs. BHPr will work with IHS to assess the number of Tribal health departments with preventive medicine residency programs to make sure that they receive targeted information about this grant opportunity and technical assistance efforts.

United States Department of Health and Human Services

Indian Health Service (IHS)

The Indian Health Service provides a comprehensive health service delivery system for approximately 1.9 million American Indians and Alaska Natives who are members or descendents of 565 federally recognized Tribes in 35 states. The IHS fiscal year (FY) 2010 appropriation was $4.05 billion. The IHS has a total of about 15,700 employees, which includes approximately 2,700 nurses, 900 physicians, 700 engineers and sanitarians, 600 pharmacists, and 300 dentists. The IHS system consists of 12 Area offices, which are further divided into 161 Service Units that provide care at the local level. Health services are provided directly by the IHS, through tribally contracted and operated health programs, and through services purchased from private providers. There are over 600 facilities in the Indian health system. The Federal system consists of 31 hospitals, 63 health centers, and 30 health stations. In addition, 34 Urban Indian health programs provide a variety of health and referral services.

The provision of Federal health services to American Indians and Alaska Natives is based on a Government-to-Government relationship between Indian Tribes and the United States, as well as numerous treaties, court decisions, and legislation. The Snyder Act of 1921 provides the basic authority for health services provided by the Federal Government to American Indians and Alaska Natives. The Indian Self-Determination and Education Assistance Act of 1975 (ISDEAA), as amended, allows Tribes to assume the administrative and program direction responsibilities that were previously carried out solely by the Federal Government. Tribes currently administer over one-half of IHS resources through ISDEAA contracts and compacts. The IHS administers the remaining resources and manages facilities where Tribes have elected not to contract or compact their health programs. The Indian Health Care Improvement Act of 1976 (IHCIA), as amended, authorizes the provision of health care services by IHS and was reauthorized in 2010 with passage of the Affordable Care Act.

Tribal Consultation Policy: *Tribal Consultation Policy.* IHS Circular No. 2006-01

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HIGHLIGHTS OF DIVISION SPECIFIC ACCOMPLISHMENTS/ACTIVITIES TARGETED TOWARD AMERICAN INDIANS/ALASKA NATIVES (AI/AN)

Tribal Consultation a Top Priority

Tribal consultation was identified as a top division priority in 2010. The four IHS priorities included:

1. To renew and strengthen our partnership with Tribes
2. In the context of national health insurance reform, to bring reform to the IHS
3. To improve the quality of and access to care
4. To make all our work accountable, transparent, fair and inclusive

Activities in 2010 included progress on the formal consultation to improve the consultation process, implementation of specific activities to improve communication with Tribes, consultations on top Tribal priorities, an increase in formal written communications to Tribes, a series of Area listening sessions and over 300 Tribal delegation meetings.

Consultation on Tribal Consultation Process

The IHS Director continued the formal consultation on how to improve the IHS Tribal consultation process. A letter to Tribes in January 2010 requested input on the 6 pages of recommendations developed by the Director's Workgroup on Tribal Consultation after two face-to-face meetings in Washington DC. The 24-member workgroup consists of elected or appointed Tribal officials from each of the 12 IHS Areas. Several recommendations were implemented as described below, including improved communication strategies, a new website, Area listening sessions, and consultations on top Tribal priorities.

Tribal Communications

On February 16, 2010, the IHS Director released a letter to Tribal Leaders to communicate improvements to the IHS Web site. The *Director's Corner* of the main page of the IHS Web site at *www.ihs.gov* was redesigned as a central address for updates on important initiatives and activities related to Agency priorities. The *Director's Corner* features press releases, presentations, Tribal Leader letters, a link to a site for updates on IHS reform activities, and other important and timely communications. The *Director's Corner* also features a new section, The *Director's Blog*, which serves as a way for the IHS Director to provide brief and timely updates on Agency activities and important announcements. These updates have increased Agency transparency and information sharing.

Tribal Consultation Website

A new website was developed in 2010 as a result of Tribal recommendations to serve as a central location to find information on IHS Tribal consultation activities. The site includes summaries of all IHS Tribal workgroups, boards and committees, all Tribal leader letters, and will include postings of current activities, including minutes and meeting summaries in the near future.

IHS Area Listening Sessions

The IHS Director initiated Tribal consultations in each of the 12 IHS Areas during FY 2010. The goal was to meet with Tribal leaders and discuss how the IHS could improve the IHS Tribal consultation process at the national and Area levels. A letter to

Tribal Leaders was issued to report progress on the Area Listening Sessions in April 2010. In FY 2010, the IHS Director convened 11 of the 12 IHS Area Listening Session meetings. Tribal leaders made recommendations on improving the Tribal consultation processes at the National, Area, and local levels and also presented numerous priority issues that include the need for more funding, especially for Contract Health Services (CHS) and Contract Support Costs (CSC). The 12th IHS Area Listening Session will be completed by the end of the calendar year.

Consultations on Tribal Priorities

IHS conducted consultation activities related to top Tribal priorities in 2010:

Annual IHS Budget Formulation

The IHS Budget Formulation Workgroup met in February 2010 to review Area budget formulation recommendations and to make national recommendations for the IHS budget. The IHS Director attended the meeting and reviewed the recommendations of the workgroup.

Annual HHS Budget Consultation

The IHS participated in the Tribal Resource Day and the Tribal Consultation Session that was held in Washington, DC, on March 4-5, 2010. The IHS coordinated responses to issues and recommendations identified during this consultation.

Contract Health Services (CHS)

The IHS Director initiated Tribal consultation on reforming the CHS program in a letter to Tribes in January 2010 and requested input on how to improve the CHS program in general, whether the formula for distribution of new CHS funds should change, and how to improve the business operations of the CHS program. Two face-to-face meetings were held with the 24-member CHS workgroup in Denver, Colorado, and the IHS Director held two CHS Listening and Best Practices Sessions with tribes in Crystal City, Virginia and in Denver CO. The CHS workgroup recommendations will be sent to Tribes for review in 2011 and specific improvements will then be implemented. Additional letters were sent to Tribes in March 2010 to inform them of the ongoing GAO study of the CHS program, and in June 2010 to update Tribes on the 2010 CHS appropriation.

Affordable Care Act/Indian Health Care Improvement Act (IHCIA)

The formal consultation on the Affordable Care Act and IHCIA was initiated in a joint HHS/IHS letter to Tribes on May 12, 2010. IHS also sent a letter to Tribes in July 2010 informing them of IHCIA self-implementing provisions. Listening sessions were held with Tribes at several Indian health meetings and with several Tribal workgroups and advisory committees.

Health Information Technology Shares

A letter was sent to Tribes in August 2010 to request input on the recommendations of the Health Information Technology (IT) Shares Workgroup. The increased needs for information technology and their impact on IHS programs, functions and services require a reassessment of the services IHS can provide and buy-back options for Tribes that manage IHS programs.

Behavioral Health

Tribes have indicated that behavioral health issues, including mental health, substance abuse and suicide, are top Tribal priorities. The IHS Director sent a letter to Tribes in December 2009 that explained the distribution of funding for the Domestic Violence Prevention Initiative, appropriated by the Omnibus Appropriations Act of 2009, Public Law 111-8. The purpose of the DVPI initiative is to support a national effort by the IHS to address domestic violence and sexual assault within AI/AN communities. The IHS Director and the SAMHSA Administrator sent a letter to Tribes in September 2010 to provide an update on collaborative behavioral health activities.

Access to Quality Healthcare

The IHS Director and the HRSA Administrator sent a letter to Tribes in December 2009 to provide an update on collaborative activities. The IHS and HRSA are currently working to improve AI/AN access to Federally Qualified Health Centers through HRSA's "Find a Health Center" tool. This will allow individuals to easily locate the closest community health center by clicking on links to the tool on the IHS Web site. Both the IHS and HRSA will provide information to Tribal representatives on HRSA-funded programs that could directly benefit Tribal communities, including the process for becoming a Section 330 Federally Qualified Community Health Center or a Federally Qualified Community Health Center Look-alike.

Other IHS Consultation Activities

The Director held 192 Tribal Delegation Meetings with 446 Tribes in IHS Headquarters, during Area Listening Sessions, and at Indian health meetings during 2010. The Director also met with many of IHS' Tribal advisory workgroups, committees, and boards during the year. The IHS Director attended the White House Tribal Nations Conference in November 2009 and reviewed input from Tribes and participated in development of the report of the conference.

DIVISION SPECIFIC ACTIVITIES

In 2010, the 12 IHS Area Offices reported a number of new consultation activities and initiatives that relate to the agency's partnership with Tribes.

ABERDEEN AREA IHS

Commitment to Consultation

The Aberdeen Area IHS met extensively with Tribal Leaders, governing bodies, and organizations in 2010. The Aberdeen Area participated in 10 Governing Body meetings (Rapid City, Pine Ridge, Rosebud, Belcourt, Eagle Butte, Fort Yates, Lower Brule, Sisseton, Wagner, and Winnebago); met with the Aberdeen Area Tribal Chairmen's Health Board and its officers on multiple occasions; held seven meetings with the Great Plains Tribes; met with the Urban Tribal Health Directors; participated in both the Rapid City Consumer Conference and the National Indian Health Board Conference; participated in State of South Dakota Medicaid consultation meetings on Contract Health Service and Behavioral Health services in March and June 2010; and participated in over 25 meetings with individual Tribal leaders or representatives.

Fiscal Year 2010 Budget Consultation

Great Plains Tribal leaders were consulted on the fiscal year 2009 budget results in November 2009. The major outcomes were sharing each of the Area Office and Area Programs budgets including funds status results, and the subsequent passage of a

Great Plains Tribal Chairmen's Health Board Resolution regarding the distribution of fiscal years 2008 and 2009 increases to address prior year third party deficits.

Fiscal Year 2013 Budget Formulation Consultation

The Great Plains Tribal leaders and representatives prioritized the Area fiscal year 2013 budget request at the December 2010 budget formulation consultation meeting.

Affordable Care Act

The Great Plains Tribal Chairmen's Health Board presented timely and useful information to the Aberdeen Area tribes in attendance at a December 2010 meeting for this purpose. A follow-up meeting is planned for February 2010. A contract redesign proposal is anticipated from a Title I Tribe to incorporate long-term care language and several other Title I Tribes have expressed similar interest.

Northern Plains Tribal Public Health Summit

The Northern Plains Tribal Epidemiology Center (NPTEC) and Great Plains Tribal Chairmen's Health Board (GPTCHB) convened the Northern Plains Tribal Public Health Summit on September 1-2, 2010, in Sioux Falls, South Dakota, to provide information on the local public health infrastructure and to participate in strategic planning activities focused on the Ten Essential Public Health Services. Representatives of 9 Tribes attended. Organizations presenting included the IHS, the CDC, National Association of Local Boards of Health, and the National Indian Health Board. The goals of the summit were to: present an overview of public health assessment and strategic planning instruments; provide a regional and national context for Tribal public health performance; strengthen communication and nurture relationships among Area Tribes; foster Tribal leadership public health capacity and performance; and, facilitate strategic planning and identify technical assistance needs.

Sharing Best Practices for Community Wellness

The Aberdeen Area IHS partnered with Great Plains Tribal Epidemiology Center for the 2010 Community Wellness Champion Forum, in Rapid City, South Dakota. The event showcased best practices throughout the Aberdeen Area and offered Tribes an opportunity to share their expertise in developing and implementing community wellness projects/programs. The Web site address for the accompanying booklet is http://workgroups.ihs.gov/sites/abr/ipc/shared%2oDocuments/Forms/AllItems.aspx.

Aberdeen Area Hospital Project Nominated for Best American Recovery and Reinvestment Act of 2009 (ARRA) Project

The Eagle Butte IHS Hospital replacement project was nominated as one of the Department's "Best ARRA Projects." The project, which has an overall budget in excess of $110 million, is expected to open in late 2011.

ALASKA AREA IHS

Alaska Area Consultations

The Alaska Area IHS conducted the following Tribal consultations: (1) Annual Tribal budget formulation consultation for FY 2012 (11/18/2009); (2) twice-yearly "Mega-Meetings," with the Alaska Native Health Board and its Tribal membership from throughout Alaska (2/24/2010 and 8/10/2010); and, (3) consultation, including comment solicitation and discussion on the proposed intra-Area distribution of FY 2010 Inflation, Pay Act, Population Growth and CHS program increases. Funds were distributed taking

Tribal recommendations into consideration. The Alaska Area Director held added consultation with Tribes and Tribal organizations at their request including: Northwest Arctic Leadership Team Strategy Session (12/16/09) and Tanana Chiefs Conference Annual Convention (3/15/2010).

Consultation with Senior Government Officials

The Alaska Area IHS arranged for Alaska Native Tribes and Tribal organizations to consult with senior Federal officials in the following events: (1) the IHS Director's Listening Session, which directly addressed the IHS Director's initiative to improve relations with Tribes (8/11/2010); (2) Veterans Round Table for Veterans in the Yukon-Kuskokwim Delta Region, which helped to improve access to healthcare for Alaska Native veterans in rural Alaska and strengthened the relationship between the IHS and the U.S. Department of Veterans Affairs (VA) (8/11/2010); (3) Consultation on Meaningful Use of Electronic Health Records (EHR) with the IHS Chief Information Officer, which helped to ensure that Tribal health facilities and providers benefit from ARRA financial incentives available from Medicare and Medicaid (8/17/2010); and (4) "HHS Day" with the Alaska Native Health Board (White House Deputy Associate Director of Intergovernmental Affairs; Director, IHS; SAMHSA Administrator; Commissioner, Administration for Native Americans; Director of External Affairs, CMS; and, Region X Director, HHS), which improved US-Tribal relations and increased understanding among Federal officials of issues affecting the health of Alaska Natives (8/12/2010).

IHS Joint Venture Construction Program (JVCP)

Alaska Area IHS provided consultation and technical assistance to six Alaskan Tribal Health Organizations (THOs) concerning the IHS JVCP. In a national competition, ten projects were invited to participate and negotiate a JVCP Agreement with IHS. Five of these participants are Alaska Area THOs, two of which have successfully entered into JVCP agreements with IHS. Two more are negotiating JVCP agreements with the IHS.

ALBUQUERQUE AREA IHS

Albuquerque Area Consultations

The current Acting Area Director has consulted with Area Tribes on a variety of issues. IHS consulted with Tribes during interviews for the new Albuquerque Area Director.

Albuquerque Area Telebehavioral Health (TBH) Initiative

Coordinated efforts at the Area level have resulted in the use of TBH throughout the Albuquerque Area IHS. Inter-Agency Agreements with the University of New Mexico Center for Rural and Community Behavioral Health and the University of Colorado Health Sciences Center were finalized to provide services, education, and evaluation. The Area purchased 15 televideo units (televideo equipment is now available at all Service Units) and 100 licenses to allow desktop- or laptop-based webcams to interface with the stand-alone televideo units, significantly decreasing the cost of entry for programs and providers. Availability of TBH has a demonstrated ability to expand patient access to psychiatric services. Patient impacts of the initiative include more than 1,000 patient contacts in the highest need/highest risk facilities, with little or no other access to this type of care; more than 15,000 fewer miles driven by patients and families; and more than 800 provider hours converted from travel-time to service delivery (the result was a $50,000 reduction in associated travel costs). Many patients report that they prefer Behavioral Health service via televideo due to increased confidentiality.

The Albuquerque Area IHS has established an Area telehealth policy that will serve as a template available for other IHS Areas. The Albuquerque Area IHS expects direct service expansion in next 6 months (December 2010 – May 2011) that will include nine initial TBH sites as well as expansion of direct services in urban settings via a Memorandum of Understanding (MOU) with the Albuquerque Job Corps program and the Southwest Indian Polytechnic Institute (SIPI). The Albuquerque Area IHS will also provide TBH services to other IHS Areas, including the Aberdeen and Navajo Areas, and telepsychiatry support services to Chemawa Boarding School (Portland Area). Telehealth support activities have indirectly led to the Mescalero Apache Tribe being awarded multi-year State and Federal grants.

BEMIDJI AREA IHS

Tribal Consultation/Partnerships

The Bemidji Area Director conducted three regional consultation sessions in the States of Minnesota, Wisconsin and Michigan to seek input and recommendations from all Tribal constituents. The Area received five recommendations which are being implemented across the Area. These recommendations include: 1) Using Technology to improve communication; 2) Rotating meetings or telecasts; 3) Allowing mid-level Tribal representation for the Tribe (if requested); 4) Requesting the Area Lead Negotiator's attendance and central point of contact at all Health Director meetings and; 5) Including the Mental and Behavioral Health Directors in meeting and decisions. Additionally, two Tribal Advisory Board and Resource Allocation meetings occurred to solicit Tribal procedural recommendations for distributing and allocating new congressional appropriations. The Bemidji Area also made two P.L. 93-638 presentations to two tribes and is currently assisting the Leech Lake Tribe with PJD/POR documentation. Locally, the Service Units are including Tribal Health Directors at recurring Governing Board meetings, have conducted listening sessions and community forums for beneficiaries and continue work to improve clinical data sharing for the singular patient population.

Information Technology Initiatives

The Bemidji Area hosted an Information Technology (IT) Technical Support Conference in Green Bay, Wisconsin, on September 13-17, 2010, which provided detailed information on Meaningful Use (MU) requirements, IT security, telecommunications, and RPMS/EHR implementation strategies for IHS, Tribal, and Urban (ITU) programs. This recurring IT technical conference ensures that ITU programs stay current and focused on changing health information technology requirements. Additionally, the IT program consulted with Tribal programs to select, purchase and install videoconferencing equipment for 100 percent of all Tribal sites. As a result of this deployment, Tribal programs leveraged this technology to improve health care. For example, the Forest County Potowatomi Community expanded their alternative care agreement with the Bemidji Area, (originally for prevention and chronic disease management) to include health promotion and disease prevention (HPDP) services.

Environmental Health Initiatives

Two environmental Health initiatives are sustainability and bullying in schools. For example, the Bemidji Area field employees supported the Greater Leech Lake Tribe's efforts to develop a "Green Team," which is dedicated to community resilience regarding climate change and post peak oil initiatives. The Green Team successfully received a Tribal Resolution banning Styrofoam. The Team also acquired conservation funds from the local utility company to implement energy saving strategies at Tribal buildings (e.g.,

energy efficient light bulbs). As a result of this collaboration the Bemidji Area exceeded environmental sustainability and Audit requirements by completing 100 percent versus the required 25 percent. The Area's facility information will be submitted prior to the deadline.

Initiative to Stop Bullying in Schools

Bullying in schools is in the forefront of the Nation's awareness and the Bemidji Area District Environmental Health employees continue to build school programs based on a pilot program at the Lac Vieux Desert Tribe called "Bully-Proofing Your School." Area staff provided training and assistance to six schools, serving five Tribes, to implement this program in their communities. The data collected has reduced bullying behaviors in these schools.

BILLINGS AREA IHS

Budget Formulation

The Billings Area IHS conducted the Budget Formulation meeting with Tribes in December 2009 for the 2012 budget proposal. Billings Area Tribes have maintained that CHS is the main priority for increases in the IHS budget. This meeting has been scheduled for December 13-14, 2010, for the 2013 IHS Budget.

Distributed Congressional Initiative Funding

The Billings Area IHS distributed new funds to Tribal Governments for the following initiatives: (1) Methamphetamine and Suicide Prevention Initiatives (more than $2.1 million in FYs 2008 through 2010) and (2) Domestic Violence Initiatives ($489,000 for FYs 2010 through 2011).

Part of National and State Task Force H1N1 Vaccination Distribution

The Billings Area IHS was part of a national and State task force in the distribution of H1N1 vaccination. The goals and objectives were to support the Service Units, Tribes, and Urban Centers in logistics and planning for novel H1N1. This was accomplished by monitoring task force milestones, clear communications, and close collaboration and partnership with participants.

Hosted the 2010 National Direct Services Tribal meeting

In conjunction with the Billings Area Tribes, the Billings Area IHS hosted the 2010 National Direct Services Tribal meeting. The meeting was held August 24-26, 2010, in Billings, Montana. Nearly 400 people from throughout the country attended the highly successful meeting. The IHS Director also took the opportunity to address the Billings Area staff at this time.

Access to Care, Quality of Care, Customer Service, & Administration Meetings with Tribes

The Billings Area IHS invited all Tribal Governments and Tribal Health Departments to the respective Service Unit Governing Body meeting held each quarter. Topics discussed included, but were not limited to, Access to Care, Quality of Care, Customer Service, and Administration.

CALIFORNIA AREA IHS

Tribal Consultation Plan

The IHS/CAO Director completed a Tribal Consultation Plan, consisting of 10 initiatives for FY 2010/2011 and distributed it to all 103 Tribal Chairpersons in April. Tribal

governments/Tribal organizations were asked to identify additional consultation activities they would like implemented. The IHS/CAO leadership team will review progress on each of the 10 initiatives, review Tribal input, update the plan, seek additional Tribal input, and implement the revised plan in April. Successful implementation of this plan and related activities strengthens the government-to-government relationship and Tribal sovereignty between the IHS/CAO and California Tribes. The IHS/CAO is 100% contracted/compacted under P.L. 93-638 and has no IHS hospitals

Annual Tribal Leader's Consultation Conference

The Annual Tribal Leaders' Consultation Conference was held March 9-11 in Cabazon, with 61 Tribal Leaders and 280 attendees. The IHS Director conducted Listening Sessions with Tribal Leaders on the first day to become aware of health issues specific to Indians in California. The California Youth Regional Treatment Center (YRTC) initiative stood out as a concern among Tribal leaders. The IHS Director pledged her support at the IHS headquarters level, to overcome obstacles and streamline processes. As a result, the purchase assembly (escrow package) for the southern property "Taylor Ranch" is under final review by IHS Headquarters.

For the first time, the IHS/CAO shared the stage of the Annual Tribal Leaders' Consultation Conference with the State of California – Department of Health Services (second day) and the DHHS Region IX (third day), for the purpose of Tribal consultation. Tribal leaders had the opportunity to discuss key health issues and consult with major health entities/officials in one three-day forum. It encouraged information sharing, improved collaborations with Tribes/among health agencies, and allowed State and federal officials to hear first hand, and to respond to, health concerns among California Indians. These Tribal consultations were recorded by a court reporter.

After conducting Tribal consultation on the "IHS/CAO California Area Tribal Advisory Committee (CATAC) Policy" and the "IHS/CAO Tribal Consultation Policy" at the Annual Tribal Leaders' Consultation Conference in March, the IHS/CAO Director sent the "draft policies" to 103 California Tribal Chairpersons for input. Tribal responses were discussed at the June CATAC meeting and the policies will be updated with minor revisions. The IHS/CAO and California Tribes are implementing Tribal consultation policies that are current and beneficial to both parties, the CATAC, and California representatives to national IHS workgroups.

California Area Tribal Advisory Committee (CATAC)

The CATAC, comprised of 15 elected Tribal members representing all Tribes in four regions of California, was established in 1998 to provide advice/guidance to the Area Director. The IHS/CAO conducted the following CATAC meetings: December 15, 2009 in Sacramento; March 8 in Cabazon; and June 29-30 in Sacramento. The outcome was direct Tribal input into the IHS/CAO Budget Formulation submission, finalizing plans for a 3-day conference strictly for Tribal consultation, and clear guidance on the YRTC initiative.

Youth Regional Treatment Centers

The IHS/CAO continued efforts to purchase properties in northern and southern California, to construct two youth regional treatment centers (YRTCs). The IHS/CAO Director consulted with Tribal leaders at the Annual Tribal Leaders' Consultation Conference in March and provided official YRTC updates by e-mail to all 103 Tribal

Chairpersons on April 30, July 1, August 10, and September 29. The IHS/CAO Director consulted with the California Area Tribal Advisory Committee (CATAC) on December 15, March 8, and June 29; the California Rural Indian Health Board on June 12; and the Southern California Tribal Chairmen's Association on August 24. On September 16, the IHS/CAO and nine Tribal leaders met at Congressman McClintock's office to discuss opposition to the northern YRTC project. On September 29, formal Tribal consultation was requested from all 103 Tribal Chairpersons, regarding political/community opposition and on October 25, an additional conference call was held with Tribal Chairpersons. The outcome of all Tribal consultation was firm support to the IHS/CAO Director, to purchase the northern California property, despite opposition.

Tribal Delegation Meetings

The IHS/CAO Director conducted 14 Tribal Delegation meetings to discuss construction of new clinics, emergency medical services, contract support costs, first time services for new Tribes, and member Tribes leaving consortiums. Tribes successfully received the information and technical guidance they were seeking from the IHS/CAO Director, to make informed decisions under P.L. 93-638 contracting/compacting.

NASHVILLE AREA IHS

United South and Eastern Tribes Fall Meeting, June 14, 2010, Mobile Alabama

Consulted on Implementation and training of P.L.93-638 Title I Tribes Web-based Database to better serve the customer base consistent with the Title V Self Governance services. Positive outcomes resulted in full training and implementation by October 2010 providing for a more efficient P.L.93-638 Title I Amendment process. Consultation to allocate population growth funding vs. non-recurring allocations resulted in increased confidence of NDW. The meeting resulted in tribal feedback supportive of a recurring allocation of user population which was reflective of the increased confidence level of the NDW data and tribes were receptive to our proposed recurring allocation of population growth funding vs. previously nonrecurring allocations. Consultation on Domestic Violence Prevention Initiative and funding criteria resulted in proposals to address prevention initiative to meet timeframes which resulted in funding awards. Nashville IHS consulted with Tribes on Indirect Cost Shortfall data for submission to headquarters.

United South and Eastern Tribes Fall Meeting, October 12, 2010, Verona, NY

Participated in USET Tribes' emergency preparedness tabletop exercise conducted at the fall USET Consultation Meeting of October 12, 2010; 50 tribal leaders participated. As part of the national effort to address the H1N1 virus and emergency preparedness, 1,060 doses of vaccine were distributed throughout the Nashville Area IHS.

Access to care and Quality Improvement Activities:

Office of the Area Director met with Tribal leadership Nations of Tuscarora, Tonawanda, Mashpee Wampanoag, Aroostook Band of Micmac Indians to establish, renew and strengthen partnerships with new tribes or seeking 638 contracting and to establish access to health care for newly served populations expanding healthcare to approximately 4000 Native American patients.

Health Summit, April 2010

The Nashville Area supported the national quality improvement IPC initiative through active participation in national calls, continued development of the Area Improvement Support Team, mentoring and coaching of five IPC health clinics, and hosting an annual

3-day health summit attended by over 100 ITU health care professionals that focused entirely on improving the quality of care to the tribal nations we serve.

Government Performance and Results Act (GPRA)

The Nashville Area IHS continued to improve on GPRA performance, with the following results: (1) 14 of 17 sites met at least 10 of the 22 GPRA indicators; (2) two sites met all GPRA measures; and (3) 7 of 22 nationally-recognized dental programs were from the Nashville Area

EHR Implementation

A new Clinical Applications Coordinator led the Nashville Area's EHR implementation effort. Five new sites began implementation, eight sites continued participation, and four sites began transition activities.

Project TransAm

Project TransAm is a joint project between the IHS and the Department of Defense managed by the Nashville Area IHS and its purpose is to provide excess supplies and equipment throughout the IHS. In the past year, Project TransAm acquired and delivered $3.78 million in assets to Tribes, including 7 ambulances and 2 fire trucks.

Office of Management Support

Two Subpart J construction contracts were executed this year: one for the installation of sanitation facilities for the Jena Band of Choctaw Indians ($114,300) and the other for construction of water supply and wastewater treatment systems for the Seneca Nation of Indians ($123,500). A commercial construction contract was also executed for a $300,799 project with the Mashpee Wampanoag Tribe to serve a number of citizens' homes with community water service facilities. Other accomplishments included the implementation of an electronic Title I database that allows Tribes to track modifications to their annual funding agreements and the execution of new model funding agreements for Tribes. Accomplishments of the Division of Information Resources Management included technical assistance provided to 27 national and Area computer-based trainings held at the Area Office during the year, installation of 100 percent of software patches to all facilities within 7 days of receipt, and 98% installation of security patches within 7 days.

Office of Public Health (OPH), Nashville Area IHS

The Nashville Area Dental Officer provided 15 dental program reviews, the most of any Area, and over 40 hours of continuing education was provided to Tribal programs. In the Behavioral Health Program, a patient-focused diabetes conference was held to improve diabetes care in patients. The Area Behavioral Health Consultant managed seven programs receiving national MSPI funding, and two programs receiving national DVPI funding. In Managed Care, two trainings were held in collaboration with the CMS. A long-term contract for teledermatology was implemented to serve tribes in the South East Region.

Office of Environmental Health and Engineering, Nashville Area IHS

In 2010, the Nashville Area Division of Sanitation Facilities Construction completed 17 projects with an average duration of 2.34 years (Office of Management and Budget benchmark is 4.0 years) and initiated 26 new projects that will serve 1,237 homes with new or improved sanitation facilities. Further, the Division of Environmental Health Services provided blood borne pathogen/hazard communication training to 159 Tribal

employees during 2010, conducted 101 environmental surveys, tracked 57 WebCident incidents, and worked with Tribes to reduce repeat food service violations by 17.4 percent.

NAVAJO AREA IHS

Assisted Preparations for National Consultation on Contract Health Services (CHS)

At the request of the Navajo Nation leadership (Health and Social Services Committee of the Navajo Nation Council), Area staff consulted with Tribal leaders in preparation for the IHS Consultation on CHS funding and business practices leading to a Navajo Nation position paper on the CHS program.

Budget Formulation

The annual budget formulation consultation session with Navajo Nation elected leaders and others to develop FY2012 program priorities, policies, and budget recommendations for the IHS was held November 18-19, 2009 with 105 attendees. Two Tribal representatives were selected to attend the National IHS FY2012 Formulation Work session held on February 9, 2010.

New Public Law (P.L.) 93-638

As directed by the Navajo Nation Council, consultation with Tribal organizations increased during FY2009. A new P.L. 93-638 contract was negotiated with the Ft. Defiance Indian Hospital Board, Inc. and 6 Funding Agreements with 3 Tribal organizations and the Navajo Nation were negotiated.

Special Diabetes Program Initiative

Annual consultation with leadership from the Navajo Nation President's Office and the Navajo Nation's Health and Social Services Committee resulted in the distribution of $14,056,955 for Prevention and Treatment activities for FY2010-2011.

Working with the Department of Veterans Affairs

The Navajo Area facilitated and participated in Tribal Consultation with the Veterans Administration V.I.S.N. 18 officials regarding VA activities planned for FY2010-2011 including a VA Clinic in Chinle, Arizona, VA PTSD program staff in Chinle and Fort Defiance, Arizona, and ongoing Tribal priorities for a unique VA facility on the reservation.

Uranium Exposure Research

The Navajo Area IHS facilitated consultation with Navajo Nation elected leaders and staff from the Tribal Division of Health, the Centers for Disease Control and Prevention (CDC), and Agency for Toxic Substances and Disease Registry (ATSDR) on a FY 2010 award for a prospective study of the possible effects of uranium on a birth cohort.

MSPI/DVPI

In 2009, 11 Navajo Area programs received funds to participate in the IHS Methamphetamine and Suicide Prevention and Treatment Initiative (MSPI). $1,760,000 congressionally appropriated funds were distributed for year one. In 2010, The Navajo Area IHS received $379,000 to implement six Domestic Violence Prevention Initiative (DVPI) programs. The same consultation model for Special Diabetes was used to decide on funds distribution for MSPI/DVPI.

OKLAHOMA AREA IHS

Oklahoma City Area Commitment to Tribal Consultation

The Oklahoma City Area IHS met extensively with Tribal Leaders, health program directors and staff, and tribal health boards during 2010. On a quarterly basis, the Oklahoma City Area met with the Oklahoma City Area Inter-Tribal Health Board to address issues pertinent to the Area's health delivery system. The Oklahoma City Area initiated a practice of conducting two formal tribal consultations sessions per calendar year; the format provides for general briefings by IHS staff, open consultation on pertinent issues, and open forum for new discussion topics. The 2010 sessions were attended by over 50 representatives from the Oklahoma City Area Tribes.

Wellness Gardens and Indigenous Food Coalition

In cooperation with numerous tribes, the Area initiated worksite wellness gardens at five clinic sites, tribal schools, and elder community centers to provide daily fitness activities through gardening and increase fresh produce availability. An indigenous food coalition has been organized that will promote growing plants from Native seeds, partnering with farmers markets to bring fresh produce to clinic sites, and providing information to expand the gardens into the tribal communities.

CHS Technical Assistance Outreach

As a result of significant concerns raised by Tribes during the 2010 HHS Regional Tribal Consultation Meeting (Albuquerque, NM), the Oklahoma City Area CHS Program developed an extensive outreach program to educate I/T/U program staff, Tribal leaders, and patients on the CHS regulations and procedures as adapted to address the unique requirements of a single large Contract Health Service Delivery Area (CHSDA) and related challenges for coordination of care.

Chickasaw Nation Medical Center

As a special initiative, the first JVCP hospital was constructed by The Chickasaw Nation. The Chickasaw Nation Medical Center, a 72 bed facility that includes two medical/surgical units, a women's health unit, and emergency room with trauma capabilities opened in August 2010. This partnership between the Chickasaw Nation and IHS will not only improve access to services for the Tribe but will benefit American Indians throughout the region and will serve as a model for Tribes throughout IHS.

State of Oklahoma Health Information Exchange

In ongoing efforts to meet HITECH requirements, the OCA has collaborated with the Oklahoma State Health Department, Oklahoma Health Care Authority and Tribal leaders to ensure Tribal participation in the grant proposal and subsequent creation of the Oklahoma Health Information Exchange Trust Advisory Board. Through these efforts, in addition to a federal IHS representative, the OCA gained a representative on the advisory board to address the tribal interests.

Facilitating Medicaid Enrollment

The OCA worked with the Oklahoma Health Care Authority (OHCA) to allow IHS, Tribal, and Urban Indian program sites to access an enhanced interface for OHCA's new online Medicaid enrollment system. This "*Agency View*" allows benefit coordinators and CHS staff to assist patients with their applications and enter certain approvals without going through the OHCA. Among its many advantages, the system provides a real time eligibility determination, so if an application is created and approved during the course of

a patient encounter, that visit is billable to Medicaid. The OCA created and administers a gateway that allows I/T/U personnel to access the system without placing the burden of meeting technical connection and authentication requirements on local facilities.

PHOENIX AREA IHS

IHS/Tribal Leaders Tribal Consultation Process Committee

The Phoenix Area IHS held a Tribal Leaders Tribal Consultation Process Committee on December 7-9, 2009, and January 4-6, 2010, in Washington, DC. The Phoenix Area Tribal Representative was Mr. Alvin Moyle, Chairman, Fallon Paiute-Shoshone Tribe.

IHS/Tribal/Urban (I/T/U) Health Directors Meeting

This year's I/T/U Health Director's meeting was held on May 25-27, 2010, in Phoenix, Arizona. The Phoenix Area IHS meets with Tribal Leaders, Tribal Health Directors, and Urban Health Directors on topics of interest.

Phoenix Area Budget Formulation Tribal Consultation

Each year, Tribal representatives meet with Phoenix Area IHS staff to establish health priorities and budget recommendations for the subsequent fiscal year. From this consultation session, the Tribal representatives appoint Area representatives to attend the national formulation meetings with all Tribes and make recommendations.

Department of Health and Human Services 2010 Region IX Tribal Consultation

The Phoenix Area IHS held the HHS 2010 Region IX Tribal Consultation on April 29, 2010, in Phoenix, Arizona. Issues under discussion included Tribal Consultation for HHS, related policies and procedures, and Tribal Advisory Committee participation. Also, the Phoenix Area IHS provided testimony for Tribal and regional issues and provided Area perspectives on national Tribal policy matters.

The Proposed Nevada Area Office Plan

In April 2010, a joint Phoenix Area IHS and Nevada Tribes workgroup was established to develop a rough draft of the Nevada Area IHS Implementation Plan. The workgroup met from April through July 2010 and consulted with all Nevada Tribes on August 12, 2010. The Phoenix Area-wide consultation meeting was held in Las Vegas, Nevada, on November 4-5, 2010, and a November 5-19, 2010, comment period was provided. The draft plan was submitted to IHS Headquarters by the Phoenix Area IHS during the first week of December 2010. The final version is due to Congress by March 23, 2011.

PORTLAND AREA IHS

Consultation Sessions

The Portland Area held numerous consultation sessions with Tribes in 2010. These included the annual (FY13) IHS budget consultation; the Area's annual All Tribes Meeting; quarterly meetings of the Northwest Portland Area Indian Health Board; a meeting of Area Direct Service Tribes; four meetings of the Portland Area Facilities Advisory Board; participation in the HHS Region X consultation conference; a meeting of the Area's tribal consultation improvement workgroup; semi-annual meetings of both tribal and IHS clinical directors; a meeting with a tribal workgroup to review the Area's revised PFSA document; and a tribal workgroup meeting to recommend distribution of Domestic Violence Prevention Initiative funds. Throughout 2010 the Area consulted frequently with individual Tribes on Tribe-specific issues such as 638 contract compliance and requests for technical or resource assistance for tribal programs. The

Area also consulted with several Oregon Tribes and one Washington Tribe in response to a Tribe's request for an expanded CHSDA. The Area supported Emergency Management meetings in OR and WA; an all-Area meeting on the Affordable Care Act and the reauthorization of the Indian Health Care Improvement Act; and worked with the Office of Direct Service and Contracting Tribes to prepare briefing summaries for Area tribal delegation meetings to IHS HQ. Outcomes of tribal consultation included the Area's sponsorship of a two-day training on P.L. 93-638 which was attended by more than 80 tribal participants representing 21 Tribes. Another direct result of consultation with Tribes was the Area's commitment to play a lead role with CDC and the Area's three states to insure that tribal clinics received adequate amounts of H1N1 vaccine.

Regional Specialty Referral Centers

The Area, responding to requests from Tribes to identify potential resources for improvements to facility infrastructure and healthcare delivery systems, conducted four planning sessions in 2010 with the Portland Area Facilities Advisory Committee (PAFAC). With direction from this group of tribal leaders the Area developed a proposal for a demonstration project for a regional specialty referral center. By increasing access to specialty and secondary care, the PAFAC's concept will help alleviate Tribes' dependency on CHS funding to obtain healthcare services beyond primary care. The tribal members of the PAFAC guide the Area's effort to develop a new factor in the formula that is used to determine the priority list for construction of healthcare facilities.

Championing Information Technology and Health Data Improvement

During consultation sessions dating back 20 years, NW Tribes have stressed the importance of information technology and health data. During 2010, the Portland Area, in response to requests from Tribes, provided significant information technology (IT) support on several fronts. Strengthening the Area's Wide Area Network (WAN), increasing the number of tribal clinics utilizing the IHS-EHR, investment in Vista Imaging, use of new RPMS and data applications are examples of how the Portland Area has responded to requests from Indian Tribes to stay abreast of the latest IT developments impacting the quality and efficiency of health care delivery.

Leveraging Resources through Collaboration

Enhanced collaboration with Tribes, while also partnering with states, Federal agencies, and private organizations, has resulted in numerous projects and initiatives. In support of emergency preparedness the Area worked with HHS Region X to plan an emergency preparedness conference for Oregon Tribes; coordinated with Washington Tribes impacted by winter storms; and worked with FEMA to ensure that Tribes had access to disaster assistance. An Area-sponsored immunization conference was attended by immunization registry representatives from Oregon, Washington, and Idaho, along with health professionals from local sites. Training on the RPMS immunization package was provided and local trainings and work sessions were conducted to help Tribes update their RPMS immunization registries with data from state registries.

TUCSON AREA IHS

Engaging Tribal Stakeholders in the Agency Budget Formulation Process

The Tucson Area IHS actively engaged Area Tribes in the formation of FY 2010 Health and Budget Priorities. In addition to hosting three meetings on 12/8/09, 12/9/09 & 2/4/10, the Area I/T/U budget group worked as a team to develop budget needs and health priorities. The Pascua Yaqui Tribe (PYT) commented positively on the process

and Tohono O'odham Nation (TON) Chairman Ned Norris was complimented for doing an outstanding job for his testimony to the Secretary HHS, during the IHS 2012 Budget session. The TON's Chairman's engagement is an example of the Tucson Area Tribes' active participation in the budget formulation process.

Facilitating Tribal Contracting

The Tucson Area IHS responded to a request from the PYT for consultation and technical assistance regarding development of a Title I contract to assume administration of the CHS program. Six pre-proposal consultation and technical assistance meetings were held with the PYT on 11/3/09, 11/19/09, 12/4/09, 12/14/09, 2/17/10, and 3/30/10. Also, six negotiation consultation meetings with the PYT were held on 7/1/10, 7/14/10, 7/28/10, 8/13/20, 8/18/10 and 9/10/10. As a result, the PYT was able to develop, negotiate, and sign a comprehensive contract proposal. Implementation was effective on October 1, 2010.

Consultation Efforts Result in Effective Action on Tribal Priorities

The Tucson Area IHS engaged in a continuous effort to incorporate consultation with Tribal leadership at all levels (program, Service Unit, and administration). Through this effort, the Tucson Area IHS has addressed each Tribe's top priorities by taking the following action steps: 1) beginning on April 22, 2010, increased frequency of consultation meetings with TON leadership and health department representatives from quarterly to bi-monthly. Additional FY10 meetings were held on 7/17/10 & 9/23/10; 2) provided training to the TON on the Title I contracting process in a special consultation session on 2/18/10; 3) held a special meeting with both the TON and the PYT to present the Area residual and Tribal shares determination process and methodologies on 3/18/10; and 4) followed PYT recommendations regarding the schedule and negotiations process for their Title I contract proposal (7/01/10 through 9/10/10).

Improving Patient Care through Technology and Automation

The Tucson Area IHS launched four initiatives employing office automation and EHR to improve patient care by: (1) participating in the Patient Health Record (PHR) pilot. This tool will allow patients to access their individual health information electronically and has positive implications for the IPC and Meaningful Use requirement for CMS; (2)implementing a Unified Database (UDB) on 10/1/10 between all (4) service unit facilities; (3) implementing an automated telephone system based on tribal feedback at the Santa Rosa Health Center so that when patients call, they hear an automated listing of department extensions in either English or in the Tohono O'odham language and; (4) improving patient access to care by implementing an after (work) hours nurse triage line at the San Xavier Health Center so patients may call for medical information and advice (perhaps) eliminating a trip to an emergency room or urgent care.

Sponsored the Third Annual American Indian Veterans Symposium

The Tucson Area IHS co-sponsored the Third Annual American Indian Veterans Symposium on 11/7/09 to promote benefit eligibility for American Indian Veterans and partnered with several TON Tribal programs in hosting the first annual "Family Wellness Day" ("Apedag Tash") on 6/19/10. The Area also established five new collaborative agreements with universities and colleges to support health professional student rotations and collaborate on construction of wastewater disposal and water supply facilities serving 28 homeowners on the TON reservation.

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and Medicaid Enrollment Outreach

The Tucson Area IHS received a $300,000 grant from the CMS for Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) outreach and enrollment in April 2010. The Tucson Area convened a committee of TON and PYT health department members and IHS staff and sponsored a training conference on 7/30/10 with educational presentations by representatives of the Arizona State Medicaid program (AHCCCS), CMS Region IX, and the Social Security Administration. Next steps include marketing outreach efforts to the community and training new Patient Benefit Coordinators to accomplish outreach plans for tribal communities and assisting patients with enrollment.

Implementing Best Practices to Improve Patient Care

IHS leadership continued to host TON quarterly patient advisory committee (PAC) meetings on 10/22/09, 1/21/10, 4/15/10 and 8/12/10. The Tucson Area IHS fully implemented the IHS IPC Family Practice Model at all Area Service Units and in addition to the PAC meetings, was successful in having twelve IPC collaboration meetings on the second Friday of each month in FY 2010.

The PAC and IPC collaboration meetings are held to discuss health issues, provide educational information, and solicit opportunities for improvement between the TON Health Department and the Tucson Area IHS. PAC meetings are held at the Sells Hospital. Because of the vast distances of the health care facilities, IPC collaboration meetings are tele-videoed between four (4) service unit facilities with TON and District Health Committee members as well as community members actively participating to educate and discuss health issues and initiatives.

Tucson's successful tribal collaboration as well as coordination with State, County and national agencies was critical in successfully promoting both seasonal influenza and H1N1 vaccinations in the Tucson area during the 2010 season.

AMERICAN RECOVERY AND REINVESTMENT ACT ACTIVITIES SPECIFIC TO TRIBES

The IHS consulted with AI/AN Tribes regarding the $500 million American Recovery and Reinvestment Act of 2009 (ARRA) funding at various Tribal conferences and meetings in FY 2009. The ARRA funds were distributed by the IHS as follows: health facilities construction ($227 million); maintenance and improvements ($100 million); health information technology ($85 million); sanitation facilities construction ($68 million); and health equipment that will help improve health care in Indian Country ($20 million). In FY2010, all funding was obligated by the end of the fiscal year. The IHS Director, responding to Tribal input, sent a letter to Tribes making funding available for Tribes that are not using RPMS for their electronic health record. The IHS Areas made significant progress in ARRA related projects.

ABERDEEN AREA IHS

The Aberdeen Area IHS received $113 million in ARRA funds to carry out projects on reservations across the 4-State region: maintenance and improvement ($15.2 million); medical equipment ($1.286 million); regular sanitation facilities construction ($6 million); sanitation facilities construction from the Environmental Protection Agency [EPA] ($6 million); and new health care facilities construction ($84.5 million). Many Area Tribes have taken control of their

projects and a few are already complete. The Eagle Butte IHS hospital replacement project, which has an overall budget in excess of $110 million, should open in late 2011. The facility was nominated as one of the Department's "Best ARRA projects." The Aberdeen Area IHS met its 2010 goal of obligating all ARRA funds into projects. The refined goals now include project completion and disbursing the funds to the contractors as the work is completed.

ALASKA AREA IHS

Total ARRA Implementation

The Alaska Area IHS obligated over $200 million in ARRA funds including: 14 sanitation facility construction projects ($14.2 million); Nome hospital construction ($142.5 million); Computed tomography (CT) scanner ($0.7 million); 21 medical equipment projects ($1 million); and 37 health facility maintenance and improvement (M&I) projects ($19.6 million). Also, in collaboration with the EPA, the Alaska Area IHS obligated (11) Safe Drinking Water Act projects ($8 million) and, 19 Clean Water Act projects ($19.9 million).

Health Information Technology

The Alaska Area IHS assisted the IHS Office of Information Technology with distribution of Health Information Technology ARRA funds, creating funding documents and communicating with Tribal organizations to execute agreements and distribute funds.

Nome Hospital

A topping off ceremony was held for the new Nome Hospital on May 26, 2010, marking the moment when the highest structural point in the building has been completed. To celebrate, the last steel beam was signed by Tribal and community leaders, hospital staff, and honored guests and hoisted into place. This project provides new and expanded inpatient and outpatient services to over 20 remote Alaska Native communities, serving a population of over 8,000 patients.

ARRA Maintenance and Improvement (M&I) Projects

Several M&I projects were funded through the ARRA that would have not been funded through routine annual M&I appropriations. These include: roof and window replacement and exterior siding at Mt. Edgecombe Hospital in Sitka, Alaska; renovating the woman's clinic and laboratory at the Anchorage Native Primary Care Center in Anchorage, Alaska; renovating the electrical distribution system and emergency generator at Kanakanak Hospital in Dillingham, Alaska; and constructing a new birth postpartum center at the Alaska Native Medical Center in Anchorage, Alaska.

Sanitation Facility Construction

Years ago, the village of New Stuyahok began having problems with its sewer disposal lagoon. Unable to handle increased volume of raw sewage due to community growth, the lagoon began overflowing into the Nushagak River. The green algae bloom that formed as raw wastewater entered the river caused local residents and downstream communities great concern. The river passes several villages and drains into Nushagak and Bristol Bays, home of one of the world's largest salmon fisheries. The IHS, EPA, Alaska Native Tribal Health Consortium (ANTHC), and the Native Village of New Stuyahok collaborated on an ARRA funded project. Funding from the ARRA allowed for project completion by 2009. The facility was built to accommodate current and future development. The green algae bloom has disappeared and communities downstream are relieved that the river they depend on for subsistence foods is no longer contaminated by upstream wastewater discharge. An ARRA sanitation facility project of

similar scope and impact was also completed in Gulkana, Alaska from July through November 2009. Alaska Native residents rely on fish wheels on the Gulkana River to harvest subsistence salmon and on a robust sport fishing guide service that provides significant economic relief to the community.

BEMIDJI AREA IHS

For IHS, regular ARRA eight projects totaled $1.978 million. To date, 33 percent of ARRA funds have been disbursed. Of the $692,870 made available to the Area for HIT ARRA projects, $483,693 has been awarded through purchases made by the IHS OIT and used to purchase IT equipment supporting the adoption of a certified EHR and meeting MU requirements. In addition, the Area's Division of Sanitation Facilities Construction ARRA projects, including those funded through the EPA, have been completely obligated. Similarly, there were two EPA ARRA funds: The Clean Water Act funds allowed for six projects totaling $1.590 million, which was 39 percent disbursed. The Safe Drinking Water Act ARRA funding allowed for 6 projects totaling $1.6927 million, of which, 31 percent was disbursed. Likewise, the Area's Division of Facilities Management ARRA funds were used to purchase medical equipment and for M&I activities to reduce the Backlog of Essential Maintenance, Alteration, and Repair (BEMAR). For M&I, there were 38 awards, totaling $5.08 million (completed obligated), and 87 percent disbursed. For equipment ARRA funds, there were 20 awards that totaled $893,000, which were 99.7 percent obligated and 93 percent disbursed. For Medical Equipment, there was one award of $184,828 to the Mille Lacs Band for Digital Radiology.

BILLINGS AREA IHS

In FY 2010 the Billings Area IHS entered into contractual agreements with Tribal organizations in excess of $7 million. A majority of the projects are still in progress.

CALIFORNIA AREA IHS

Information Technology (IT)

The IHS/California Area IHS (CAO) assessed IT needs and sought input from all Tribes to ensure Tribal IT needs were met and to ensure a successful state-of-the-art video conferencing environment that would provide rapid deployment/full support of the EHR system. A base amount ($6,000) was distributed to each Indian health program. Total ARRA IT funds allotted to the IHS/CAO was $530,408. Additional funds were made available to programs with larger active user populations and facilities.

Maintenance and Improvement (M&I) and Medical Equipment

The IHS/CAO received $3,020,000 in ARRA M&I and $584,333 in ARRA Medical Equipment, for 29 Indian health facilities, of which 26 are under construction or completed. Coordination meetings were held in 3 locations in California to provide guidance to Tribal/Indian health program officials. All M&I funds were obligated by September 30, 2010, and medical equipment funds were obligated and dispersed by May 2010, four months prior to the deadline.

Sanitation Facilities Construction (SFC)

The IHS/CAO SFC program received $12.3 million in ARRA funding to serve 763 Indian homes. Six of 20 projects are complete and 10 are more than 50 percent complete. The IHS/CAO has the distinction of administering the nation's largest ARRA SFC

construction project. The Tule River Reservation wastewater project, which is funded by the IHS/EPA and valued at $8.2 million, will serve 263 homes with 9 miles of wastewater collection system.

NASHVILLE AREA IHS

The Nashville Area IHS was allotted and managed $14,062,607 secured through the ARRA that supported 43 new projects for sanitation facilities construction, medical equipment, and health care facility improvements. All of the funds were obligated by September 30, 2010, in accordance with Act requirements. The vast majority (94 percent) of the ARRA funds were awarded to Area Tribes through P.L. 93-638 contracts or P.L. 86-121 agreements. All project recipients were in compliance with recipient quarterly reporting requirements. To date, 17 projects have been completed with 54 percent of ARRA funds disbursed.

Sanitation facility construction funds were used to establish 22 new sanitation facility construction projects. Several of these projects were brought to successful completion in 2010 i.e., Expansion of a Wastewater Treatment Facility Poarch Band of Creek Indians; Leaking Water Storage Repair Yellowhill Community, Cherokee, North Carolina; Hydrant Replacements Indian Island, Old Town, Maine; Richardson Road Well Replacement Cattaraugus and Erie Counties, New York; Sanitation Facilities Construction Burning Springs Water Main Loop Cattaraugus and Erie Counties, New York; Water Treatment Plant Upgrades St. Regis Mohawk Reservation, Akwesasne, New York; Equipment Project – CT Scanner Choctaw Hospital, Mississippi; Medical Equipment Project -Dental X-Ray, Exam Tables and Dynamap Monitors Penobscot Community Health Care, Indian Island, Maine, Medical Equipment Project – Patient Bathing Tubs and Air Mattresses, Tsali Care Center-Senior Assisted Living.

NAVAJO AREA IHS

ARRA Team meetings were held monthly within the Navajo Area IHS during FY2010 with reports going to the Navajo Nation's ARRA Coordinator designated by the Navajo Nation President. All IHS-funded Sanitation Facility construction projects were obligated in August 2009 ($15 million), and all EPA funded projects were obligated in August 2009 ($13.3M). All medical equipment obligations ($1.866M) were completed as of September 9, 2010. For 27 M&I projects totaling $13.6M, all obligations were complete as of September 10, 2010. Extensive collaboration occurred with the EPA to target their funds to Navajo Nation priority projects to reduce heavy metal exposure (uranium, arsenic, and others) to individuals living in homes receiving first-time services. NAIHS also contracted for 14 ARRA projects (of 27 total M&I projects) involving improvements or repair by replacement facilities for Tribal CHR and Behavioral Health programs across the reservation. Funds were also used for video-conferencing equipment for use in Behavioral Health programs at 35 Tribal and Federal sites.

OKAHOMA AREA IHS

Sanitation Facilities Construction

The Oklahoma City Area (OCA) Sanitation Facilities Construction Division funded 37 projects through the ARRA. A total of $10,565,110 was provided, with $8,137,000 from the IHS and $2,428,110 from the EPA. A total of 24,263 eligible homes will be served with sanitation facilities as a direct result of ARRA funding.

Facility Improvement Projects

The OCA Facilities Management Division was allocated $8,531,103 in ARRA funds for 23 health care facility improvement projects at 17 facilities. These funds reduced operating costs for 6 facilities, brought 3 facilities into accreditation compliance, and improved the Condition Index (CI) for 8 facilities. The CI is a measure of an asset's condition at a specific point in time. The CI is calculated as the ratio of Repair Needs to Replacement Value.

Drinking Water Safety

Using ARRA funds, the Kickapoo Tribe of Oklahoma will be able to extend the Tribal water system by 4 miles, providing safe drinking water to an area affected by natural contamination from uranium in well water. Construction is underway.

Computed Tomography (CT) System for Claremore Indian Hospital

Funding from the ARRA purchased a 64 slice CT System for the Claremore Indian Hospital in Claremore, Oklahoma. The new CT has increased appointment capacity, substantially expanded the hospital's range of diagnostic services, and greatly improved their ability to detect cancerous growths.

IT Infrastructure Improvement Projects

Recovery Act projects significantly improved the OCA IT infrastructure. A router project upgraded or replaced existing equipment to support the increased bandwidth required for tele-video, digital imaging, and improved network security. A tele-video endpoint procurement project provided necessary equipment to support telemedicine, tele-behavioral health, and videoconference meetings. The OCA has used this new equipment to provide tele-psychiatry services to outlying facilities (approximately 28 sessions per month) with plans to double that number. The Vista Imaging project built the infrastructure to convert hard copy medical records into an electronic format. The system is in use at all OCA direct service facilities with plans to expand to Tribal facilities.

PHOENIX AREA IHS

Division of Facilities Engineering

Four ARRA-funded M&I projects were awarded to two 638 Tribes in the Phoenix Area IHS, totaling $1,415,000. A Title I Subpart J Construction contract was awarded to Fort McDowell Yavapai Nation for energy improvements at the Wassaja Memorial Health Center ($85,000). Three Title V Construction Project Agreements were completed with the Gila River Indian Community for projects at the Hu Hu Kam Memorial Hospital. The projects included $350,000 for fire protection upgrades, $145,000 for fire alarm system upgrades, and $835,000 for cooling system upgrades. All ARRA projects have been successfully implemented by the Tribes and nearing final completion.

Five ARRA-funded medical equipment projects were awarded to five 638 Tribes in the Phoenix Area IHS, totaling $128,604. All Tribes have successfully purchased and installed their new medical equipment.

Sanitation Facilities Construction Program

One ARRA-funded sanitation facilities construction project was awarded to a 638 Tribe (Gila River Indian Community) in the Phoenix Area for $850,000. The Title V Project Funding Agreement provides for construction of a new potable water storage tank and

replacement of undersized water mains. Construction is ongoing and scheduled for completion in February 2011.

PORTLAND AREA IHS

Environmental Health and Engineering Projects

The Portland Area IHS successfully developed and obligated 76 ARRA projects serving 33 Tribes, as follows: Medical Equipment (31) projects at $798,000; (29) M&I projects at $4.5 million; (16) Sanitation Facility Construction (Public Law 86-121) projects at $6.8 million. Office of Environmental Health and Engineering (OEHE) staff interacted with the recipient Tribes throughout the planning, development, and implementation stage of each of these projects. The level of involvement and interaction with Tribal leadership and staff varied according to the type of project and the delivery instrument utilized (Title I contract, Title V construction funding agreement, and/or Memorandum of Agreement). Among ARRA-funded sanitation facility projects, the new water storage standpipe serving the Lower Elwha Tribe was the first ARRA SFC project in the nation for which construction was completed and the project closed out.

Information Technology Equipment

In addition to the OEHE ARRA funding, the Portland Area IHS responded to several IHS Office of Information Technology (OIT) data calls for the purchase of IT equipment for Direct, Tribal and Urban sites. Fifty-one Portland Area sites received IT equipment from the ARRA equipment data calls. The equipment enhanced Wide Area and Local Area Network connectivity, supported the implementation of video infrastructures for telehealth programs, and electronic health records certified for meaningful use. Routers, switches, video conferencing equipment, servers, desktop computers, and laptops are examples of the equipment received. In addition, a total of $790,115 was awarded to six Title V Tribes, three Title I Tribes and one Urban program, for the development of interfaces that support reporting capabilities to the IHS from non-RPMS sites.

TUCSON AREA IHS

Environmental Health and Engineering

The Tucson Area Division of Environmental Health and Engineering successfully managed 21 ARRA projects in Facilities Management and Sanitation Facilities Construction (SFC), totaling $7.33 million. Allocations from the ARRA were fully obligated prior the end of the fiscal year. Approximately 30 percent of ARRA funding has been disbursed. Eleven of the projects are substantially complete, with three awaiting only final billing and payment. Five SFC projects use ARRA funds transferred from the EPA to the IHS. Interagency coordination has been successful in completing one project and put another at 95 percent construction completion. Another project is in the pre-construction phase, slated to start construction in December. The final two projects are out for bid, with price quotes due in December. Project monitoring and reporting has also been successful with all of ARRA recipients reporting for all M&I and SFC projects. In addition, ARRA funding for Tribal priorities resulted in pharmacy renovation for the PYT and roof replacements for the TON. Internal monitoring of project status, including financial status in the UFMS, continues at the Area level on a weekly basis in order to ensure ARRA goals are being met.

AFFORDABLE CARE ACT ACTIVITIES SPECIFIC TO TRIBES

Communication on Implementation Activities

HHS and IHS issued a joint letter on May 12, 2010 to initiate the formal consultation on the Affordable Care Act and the reauthorization of the IHCIA. HHS is the lead on implementation of the Affordable Care Act, and IHS participates in their implementation activities. IHS participated in all HHS listening sessions, outreach calls and developed educational materials including a PowerPoint presentation and a fact sheet on how the Affordable Care Act impacts American Indian and Alaska Native individuals, Tribes and Indian health facilities.

IHS is the lead on implementation of the reauthorization of the IHCIA. In June, the IHS Director requested IHCIA budget priorities from the IHS Budget Formulation Workgroup and after Area discussions, the following topics were determined to be Tribal priorities for funding under IHCIA: long term care, behavioral health, health care facilities and access to federal insurance. On July 22, 2010, the IHS Director, provided an update to Tribal Leaders on IHCIA implementation activities, including several provisions that were determined to be self-implementing. IHS has identified implementation milestones, timelines, and opportunities to coordinate with other agencies and partners. The IHS identified initial actions which may involve consultation with Tribes to fully implement over the next months and years. The IHS Director developed formal guidance to Area Lead Negotiators to negotiate the authority for provisions in the IHCIA in 2010. IHS also contracted with national Indian organizations to help with outreach and education about the provisions in the new law.

ALAKSA AREA IHS

Effective October 1, 2010, the Alaska Area IHS negotiated several newly authorized provisions of the IHCIA into the Alaska Tribal Health Compact (ATHC) and the 25 associated Funding Agreements. Additionally negotiations were successful for new authority provisions (e.g., *Payer of Last Resort*). The Alaska Area Director committed to assist Tribal CHS programs by issuing a letter to private-sector providers, which asserts that IHS beneficiaries properly referred by Tribal CHS programs may not be billed directly for services rendered.

BEMIDJI AREA IHS

Information Disseminated and Incorporated into Contracts and Compacts

The Acting Bemidji Area Director provided available information to Tribal Leaders regarding the IHCIA during two highly attended sessions: Midwest Alliance of Sovereign Tribes and the Bemidji Area All I/T/U meeting. Services authorized by the IHCIA have been successfully incorporated into Tribal Contracts and Compacts at the Tribe's determination.

Proposed Consultations or Technical Assistance

The Bemidji Area IHS will continue to provide available information regarding the Affordable Care Act and the IHCIA. Consultations are planned with Tribes to present P.L. 93-638, Title I and Title V information.

BILLINGS AREA IHS

Montana Wyoming Tribal Leaders Council

The base contract with the Montana Wyoming Tribal Leaders includes the requirement of conducting meetings with Tribal Leaders and Tribal Health Departments in disseminating information to Tribes about health concerns. The Billings Area IHS has

contracted with the Montana Wyoming Tribal Leaders Council ($100,000) for services associated with the Affordable Care Act and the IHCIA. Services are for the provision of communication and outreach to all Tribes and Tribal Health Departments through consultation, dissemination of information, and education sessions.

CALIFORNIA AREA IHS

On July 21, 2010, in response to the IHCIA, section 157, "Access to Federal Insurance," a presentation was made at the IHS/CAO Program Director's meeting that described how the Federal Employees Health Benefits (FEHB) program currently works for Federal employees.

NASHVILLE AREA IHS

The Nashville Area IHS provided $100,000 to the United South and Eastern Tribes, Inc., for the Affordable Care Act and IHCIA communications and health board activities. The Nashville Area IHS participated in the Atlanta, Georgia, Director's Listening Session with Tribal Leaders in March 2010, as well as a Department of Health and Human Services Consultation Session.

NAVAJO AREA IHS

The Navajo Area IHS (NAIHS) participates with the Navajo Nation in State meetings (New Mexico and Arizona). The NAIHS also provided consultation, education, and advice at the Tribe's request to Navajo Nation Council Committees, and Health Boards on multiple Affordable Care Act provisions.

PHOENIX AREA IHS

A meeting on Arizona Tribal health care reform implementation was held on August 17, 2010, in Scottsdale, Arizona. The goal was to provide information on how the major health insurance reform provisions contained in Affordable Care Act will impact eligible American Indians, Tribes, and the Indian health care system. Round table discussions provided an opportunity for Department Health and Human Services officials to engage with Tribal representatives regarding successful Affordable Care Act Implementation strategies.

PORTLAND AREA IHS

In collaboration with the Northwest Portland Area Indian Health Board (NPAIHB) the Portland Area IHS conducted, provided, and shared the following: a 2-day Tribal meeting on national health care reform, a newsletter delineating IHCIA provisions (April 2010); a position paper on Title I regarding State-level exchanges; and a position paper on individual insurance mandates. Multiple Area Tribes and Portland Area staff members attended the November 1-2, 2010, Long Term Care Meeting. In addition, the Area Director has provided updates on the IHCIA at Health Board and Clinical Director meetings.

TRIBAL DELEGATION MEETINGS

During Fiscal Year 2010, the IHS Director met with over 300 Tribes during 48 Tribal Delegation Meetings (TDMs) at IHS Headquarters and major Indian health conferences, such as National Indian Health Board Annual Consumer Conference and the National Congress of American Indians, as requested by Tribal leaders. Tribal leaders and representatives frequently request highly-tailored consultations with the Director and Deputy Directors of the IHS to discuss pertinent health policy and program management

issues concerning the provision of health services to the Indian population. In accordance with IHS Circular No. 91-3 (1991), IHS Headquarters Tribal Delegation Meetings (TDMs) follow a formal process that includes arranging briefing documents to ensure that IHS staff are properly briefed and prepared to respond to questions and requests of tribal delegations during the meeting. In addition, issues requiring follow up will be addressed in a timely manner.

The Director also met with 446 Tribes at Area Listening Sessions and hosted 144 individual, one-on-one meetings with Tribes and Tribal organizations. The usual format for the Listening Sessions was a general session with the IHS Director and Tribes in the morning, followed by 10 to 20 minute meetings with individual Tribes for the rest of the day. In sum, the Director hosted a total of 192 meetings with 446 Tribes in Fiscal Year 2010.

AGENCY TRIBAL TECHNICAL ADVISORY GROUP

Director's Tribal Advisory Workgroup on Consultation

The Workgroup consists of 24 elected or appointed Tribal officials from each of the 12 IHS Areas and is charged to recommend improvements on the IHS Tribal Consultation process to make it more meaningful, effective and accountable. In FY 2010, formal notification was provided through three letters to Tribal Leaders. Three face-to-face meetings were held to discuss recommendations to improve the IHS Tribal consultation process; two meetings were held in Washington, D.C. and one was held in Denver, Colorado.

Tribal Self-Governance Advisory Committee (TSGAC)

Comprised of Tribal leaders from each IHS Area, the IHS TSGAC provides advice to the IHS Director and assistance on issues and concerns pertaining to Tribal Self-Governance and the implementation of ISDEAA Self-Governance activities within the IHS. On a quarterly basis, the TSGAC meets to confer, discuss, and reach consensus on specific Self Governance issues. The TSGAC is supported by a technical workgroup whenever situations warrant further research and review to address a policy issue. Quarterly TSGAC meetings were held during 2009 and 2010 included various topics, including a meeting with the IHS Agency Lead Negotiators and a meeting on national best practices on GPRA for tribally-operated health programs. Fiscal Year 2010 TSGAC Highlights include holding the 2010 Annual Self Governance Conference convened in Scottsdale, Arizona with over 800 conference participants and a 1-day Self-Governance Training on ISDEAA Title IV and Title V authorities. The TSGAC also developed a Self-Governance Strategic Plan to address Agency health, budget and legislative priorities, including Title VI of the "Tribal Self-Governance Amendments of 2000" (P.L. 106-260), enacted August 18, 2000.

Direct Service Tribes Advisory Committee

The IHS Direct Service Tribes Advisory Committee (DSTAC) was established in FY 2005 to provide leadership, advocacy, and policy guidance on behalf of those Tribes receiving health care services directly from the IHS. The DSTAC is comprised of elected/appointed Tribal Leaders from 10 IHS Areas with Direct Service Tribes (DST). Technical assistance for the DSTAC is provided by Headquarters and Area-level staff. The DSTAC met quarterly in 2010 and held monthly conference calls to conduct business. During the spring of 2010, the DSTAC participated in the IHS budget formulation process by developing and submitting Committee priorities and

recommendations for the FY 2012 budget and presenting these recommendations at the IHS National Budget Formulation Work Session. The Seventh Annual Direct Service Tribes National meeting was held in Billings, Montana with over 200 attendees.

Tribal Leaders Diabetes Committee

The IHS Tribal Leaders Diabetes Committee (TLDC) was created by the IHS Director in 1998 and continues to hold quarterly meetings. The TLDC recommends a process for distributing congressionally mandated Special Diabetes Program for Indians (SDPI) funding to the IHS Director. The TLDC also provides the IHS and Tribal leadership with an ongoing forum to discuss all matters related to diabetes and the impact of other chronic diseases on AI/AN communities. The SDPI, now in its 13th year, provides funding for diabetes treatment and prevention services at 405 IHS, Tribal, and Urban Indian health programs, serving nearly all federally recognized Tribes.

Information Systems Advisory Committee

The IHS Information Systems Advisory Committee (ISAC) was established to guide the development of a co-owned and co-managed Indian health technology (IT) infrastructure and information systems. The ISAC is an advisory body that represents the I/T/U customer base that reports to the IHS Director. The OIT consults with the ISAC on current IT issues, budget, and IT investments. The ISAC establishes annual IT priorities to be used in setting overall Agency IT priorities and budget requirements. The ISAC conducted two regular committee meetings during 2009 to accomplish their charge. The ISAC Bi-Annual Meetings provide I/T/U constituents serving on the ISAC a forum to consult, research, and develop recommendations to the IHS Director on national issues related to IT and Information Security: On February 18, 2010, the IHS convened a round table meeting in Washington DC, to discuss and to plan for IT issues specific to the Health Information Technology for Economic and Clinical Health Act (HITECH).

Information Technology Investment Review Board

Required by the Clinger-Cohen Act of 1996, the IHS created an Information Technology Investment Review Board (ITIRB) comprised of 9 permanent Tribal members, 2 rotating members, and an Ex-Officio member. The ITIRB is the official IHS review body for IT investment, including all major initiatives, funding, and expenditures. The ITIRB ensures that IT resources support the IHS mission; promote the life cycle management of IT systems as “capital investments;” and, assure IT system project approvals are based on established selection criteria.

Health Promotion and Disease Prevention Policy Advisory Committee

The Health Promotion and Disease Prevention (HP/DP) Policy Advisory Committee (PAC) is established to provide oversight and guidance for eliminating health disparities through the Director’s HP/DP Initiative.

National Tribal Advisory Committee on Behavioral Health

The IHS established the National Tribal Advisory Committee on Behavioral Health (NTAC) to support Division of Behavioral Health (DBH) efforts to improve service delivery within Indian Country. Overall, the NTAC assists in the guidance, development, and support of behavioral health services throughout the I/T/U health system, and works to ensure that services are broadly integrated, available, and culturally appropriate. The NTAC membership is made up of elected Tribal Leaders from each of the IHS Areas. The IHS convened the 2010 National Behavioral Health Conference on July 27-29, 2010, in Sacramento, California, in partnership with Tribes to discuss and to plan for

improving behavioral health in the IHS and tribally operated health programs. NTAC also developed recommendations for distribution of the Domestic Violence Prevention Initiative with the IHS Director.

Facilities Appropriation Advisory Board

The IHS Facilities Appropriation Advisory Board (FAAB) is charged with evaluating existing facilities policies, procedures, and guidelines and recommending changes if necessary; participating in the development and evaluation of any proposed new policies, procedures, guidelines, or priorities; determining when it is necessary and appropriate to seek additional consultation with Tribes; providing advice and recommendations for other related issues to the IHS Director. The FAAB consists of 12 elected Tribal Leaders and 2 IHS Area Environmental Health and Engineering Directors. The FAAB met on October 27-28, 2009, in Rockville, Maryland, to continue work on assigned tasks.

Government Performance and Results Act Measures Steering Committee

The IHS GPRA Steering Committee meets quarterly to review 5-year measures plans submitted by GPRA measure leads. Committee membership includes 13 Tribal, Urban, and IHS representatives. Technical staff is identified as needed to provide resource and technical support to this committee. The IHS convened the 2009 GPRA Coordinators Conference on November 5-6, 2009, in Sacramento, California, to discuss and plan improvement for IHS and tribally operated GPRA measures, targets, and outcomes. The IHS convened the 2012 GPRA evaluation meeting and 2013 planning session on June 29-30, 2010, in San Diego, California, in conjunction with the IHS budget formulation workgroup.

Scholarship Standing Advisory Board

The IHS Scholarship Standing Advisory Board provides advice and consultation related to the IHS Scholarship Program to the Chief of the IHS Scholarship Program. This advisory board is comprised of 10 Tribal members. This board meets annually.

Budget Formulation Workgroup

The IHS Tribal Consultation policy describes the charge and activities of the IHS Budget Formulation Workgroup. This workgroup develops its annual budget in consultation with the AI/AN Tribes and Urban Indian health organizations starting with 12 Area IHS budget sessions, a national budget meeting, a Departmental meeting, and an evaluation meeting. Fiscal Year 2010 Budget Formulation Workgroup meetings for FY 2010 to develop and to complete the FY 2012 budget cycle included the following: The IHS participated in the HHS Budget Consultation Session and Tribal Resource Day on March 3-5, 2010, in Washington, DC. The Agency also convened the FY 2012 evaluation meeting and 2013 planning session on June 29-30, 2010, in San Diego, California, in conjunction with the IHS GPRA national coordinators meeting. The workgroup also provided recommendations to the IHS Director on funding priorities for implementation of the IHCIA in June 2010.

Contract Support Costs Workgroup

The IHS Contract Support Costs (CSC) Workgroup meets to further the Federal Government's administration of CSC within the IHS. The Agency, in active participation with Tribes, developed a comprehensive CSC policy to implement the statutory provisions of the ISDEAA. The CSC Workgroup is an open, informal workgroup that

attracts a wide range of representatives from Federal, Tribal, and Tribal organizations with an interest in CSC.

National Behavioral Health Workgroup

The IHS National Behavioral Health Workgroup (BHWG) is the technical advisory workgroup for behavioral health. It is composed of AI/AN behavioral health experts from across the country, working primarily in Tribal and urban clinical settings. They advise the Agency on technical aspects of behavioral health program development and management. They also act as subject matter experts to the NTACBH and report through the NTACHB. Membership of BHWG includes 12 subject matter experts representing each IHS Area.

Information Technology Tribal Shares Workgroup

The IHS Director established an I/T/U Tribal Shares Workgroup to make recommendations on restructuring the OIT and address the IT Tribal Shares issues. The IHS Director provided two Tribal Leader Letters, dated October 23, 2008, and March 20, 2009, to formally solicit Tribal input.

IHS and Tribal Institutional Review Board Chairs Workgroup

The IHS and Tribal Institutional Review Board Chairs Workgroup is composed of approximately 20 individuals who review research proposals that need national institutional review board (IRB) review. The members are drawn from the IHS, Tribal, Urban, and academic organizations. The IHS Area and Tribal IRBs convene conference calls to discuss issues related to the protection of human subjects in research activities conducted in IHS, Tribal, and Urban settings. All human participant research conducted in IHS facilities or with IHS staff or resources must be approved by an IHS IRB. This also includes all research in tribally managed or urban facilities.

AGENCY TRIBAL CONSULTATION POLICY

The IHS has a unique Government-to-Government relationship with American Indian and Alaska Native Tribal Governments and is committed to regular and meaningful consultation and collaboration with eligible Tribes. Consultation is considered an essential element for a sound and productive relationship with Tribes. Tribal Consultation has been affirmed by Executive Order in 2000 and through Presidential Memoranda in 1994, 2004, and 2009. The IHS Tribal Consultation Policy can be referenced at IHS Circular No. 2006-01. In consultation with Tribes, the recommendations to improve the IHS consultation process this year were more about implementation of the policy, and Tribes indicated that the IHS policy did not require any changes at this time. The IHS Director's Workgroup on Tribal Consultation will review any changes to the HHS Tribal Consultation Policy in 2011 and determine if changes to the IHS Tribal Consultation Policy are needed.

United States Department of Health and Human Services

National Institutes of Health (NIH)

The mission of the National Institutes of Health (NIH) is to seek fundamental knowledge about the nature and behavior of living systems and to apply that knowledge to enhance health, lengthen life, and reduce the burdens of illness and disability. The NIH works towards this mission by conducting and supporting research in: 1) the causes, diagnosis, prevention, and cure of human diseases; 2) the processes of human growth and development; 3) the biological effects of environmental contaminants; 4) in the understanding of mental, addictive and physical disorders; and 5) directing programs for the collection, dissemination, and exchange of information in medicine and health, including the development and support of medical libraries and the training of medical librarians and other health information specialists.

The prevention, diagnosis, and treatment of diseases and conditions that disproportionately affect American Indian, Alaska Native, and Native American (AI/AN/NA) communities are a priority for the NIH. Toward this end, the NIH promotes research and capacity-building programs and conducts and supports health promotion education and the translation of research findings into programs, educational/informational tools and materials for dissemination into the AI/AN/NA community. Expanding the pool of scientists, researchers, and health professionals within the AI/AN/NA community is also essential in dealing with the many variables associated with improving the health of the AI/AN community. The NIH also recognizes partnerships and consultation as a fundamental strategy to reach the community.

This report highlights several programs and specific activities the NIH supported or participated in during 2010 in the areas of research, capacity-building and health education that are relevant to AI/AN/NA communities. These programs, aim to address disparities in health experienced by AI/AN/NA communities. This report serves as a resource and a basis of discussion to enhance agency support for Indian Country. Tribal Consultation Policy: NIH currently uses the guidance of the OS policy.

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HIGHLIGHTS OF DIVISION SPECIFIC ACCOMPLISHMENTS/ACTIVITIES

Trans-NIH American Indian /Alaska Native Health Communications & Information Workgroup

The National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS) coordinates the Trans-NIH American Indian and Alaska Native (AI/AN) Health Communications and Information Workgroup. Since 2008, the Workgroup has coordinated the distribution of more than 7000 information kits to Community Health Representatives in the areas of bone health, cancer diagnosis and treatment, diabetes, drug abuse prevention, physical activity, stroke, and sudden infant death syndrome. The kits are distributed in partnership with the Indian Health Service. The latest health information kit included culturally relevant information on cancer prevention and education and was disseminated to more than 1,400 Indian country communities representing more than 250 tribes. Under the auspices of this program, the National Institute of Drug Abuse (NIDA) sponsored the Dissemination of Drug Abuse Information to the Indian Health Service Community Health Representatives, an outreach effort that distributed drug abuse public health information to 1500 Community Health Representatives in March 2010.

National Institute of Allergy and Infectious Diseases (NIAID) Intramural NIAID Research Opportunities (INRO) Program

The INRO program is an exploratory/outreach program aimed at recruiting research trainees from populations underrepresented in biomedical research. INRO marketing includes direct listserv communication and tailored e-mails to AI/AN intermediaries, such as the American Indian Graduate Center and the National Indian Education Association; print ads (SACNAS, Winds of Change, and Tribal College Journal); support and presence at key conferences [SACNAS and American Indian Science and Engineering Society]; and ongoing relations with American Indian collegiate partners. Of the 192 applicants for INRO 2010, 7 were from American Indian or Alaska Native populations. Of those, 2 attended INRO and subsequently signed on for a research traineeship at NIAID.

National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) National Diabetes Prevention Program (DPP)

The NIDDK-led DPP was designed and conducted in collaboration with multiple NIH Institutes, Centers and Offices (ICOs), the Indian Health Service (IHS) and the Centers for Disease Control and Prevention (CDC). A study target was to ensure American Indian representation in the study cohort. Towards this end urban American Indians, as well as American Indians enrolled from the Zuni, Navajo, Gila River and Salt River reservations were enrolled. As a result, the benefits of the DPP drug (metformin) and lifestyle interventions for diabetes prevention was established to be equally as effective in American Indians as in the DPP cohort as a whole and is continuing as the DPP follow-up study or the DPPOS.

Annual Patty Iron Cloud National Native American Youth Initiative (NNAYI)

The National Institute on Minority Health and Health Disparities coordinates the annual visit of American Indian/Alaska Native students to the NIH campus through the Patty Iron Cloud National Native American Youth Initiative. In addition, other Institutes such as NIAMS, the National Institute on Aging **(**NIA), and the National Institute of Biomedical Imaging and Bioengineering (NIBIB) participate in the program by providing staff support as mentors and presenters for this academic enrichment program. *NNAYI* is designed to better prepare AI/NA high school students to continue their education and pursue a

career in the health professions and/or biomedical research. The students spend one week in Washington, DC and come to NIH for two days touring NIH laboratories and attending lectures by NIH staff.

National Institute of Neurological Disorders and Stroke (NINDS) Alaska Interest Group Collaboration

The Alaska Interest Group discussed efforts to improve collaboration and strategies to enhance current Alaska Native research activities, particularly those related to health disparities and research capacity building. This trans-NIH group included representatives from The National Heart, Lung, and Blood Institute (NHLBI), the National Center for Research Resources (NCRR), the *Eunice Shriver* National Institute for Child Health and Human Development (NICHD), and the National Cancer Institute (NCI). This resulted in a partnership between the Alaska Native Stroke Registry, funded by NINDS, and the NCRR-funded Center for Alaska Native Health Research, both of which involve extensive engagement among tribal communities and leaders.

National Heart Lung and Blood Institute Primordial Prevention of Overweight in American Indian (AI) Children (PTOTS)

This randomized controlled trial is testing the effectiveness of an intervention to improve nutrition and physical activity in American Indian toddlers. A birth cohort of approximately 600 children from six Indian communities, born over an 18-month period, have been randomized to test whether the community and family-based interventions can alter feeding practices (breastfeeding, sugared beverage consumption, timing and type of introduction of solids) and parenting, to reduce sedentary lifestyles (delayed introduction of television and creating play opportunities). The primary outcome variable is body mass index. This partnership includes Kaiser Permanente Research Foundation, Northwest Portland Area Indian Health Board, the University of Arizona, and the Colville, Coeur D'Alene, Salish Kootenai, Siletz, and Umatilla Native Communities. Data collection is nearly complete, with the goal to reduce overweight and obesity in AI infants and toddlers. At the completion of the study in 2010, the results will be disseminated to other Native communities.

NHLBI Healthy Children, Strong Families and Supportive Communities Intervention

This is a randomized controlled trial of 150 American Indian (AI) pre-school children and family caregivers to test the effectiveness of a mentored home-visiting and group support family-based intervention to improve nutrition and physical activity levels versus a comparison group that receives the written intervention materials alone. The primary outcome variable is body mass index. This partnership includes the University of Wisconsin, Great Lakes Inter-Tribal Council, Inc., and the Bad River Band of Lake Superior Chippewa Indians, Lac du Flambeau, Oneida, & Menominee Tribes. Data collection is nearly completed, with a goal of reducing overweight and obesity in AI pre-schoolers. At the completion of the study in 2011, the results will be disseminated to other Native communities.

NHLBI Strong Heart Family Study

This is the second examination of extended families ascertained from the original Strong Heart Study cohort of 45-74 year old American Indians from 13 tribes in three geographically-diverse areas (Arizona, Oklahoma, and North/South Dakota). This study is genotyping markers across the genome for use in linkage analyses with various cardiovascular risk factors and diseases. In addition, the original cohort continues to be

followed for morbidity and mortality surveillance. This partnership includes the University of Oklahoma Health Sciences Center, MedStar Research Institute, Southwest Foundation for Biomedical Research and the Weill School of Medicine at Cornell with the 13 Tribes: Apache, Fort Sill Apache, Kiowa, Comanche, Wichita, Delaware, Caddo, Gila River Indian Community (Pima), Salt River Indian Community, Ak-Chin Indian Community, Oglala Lakota, Cheyenne River Sioux, and the Spirit Lake Tribe.

This study recently completed the second examination of the family cohort to identify genes and genetic variants related to cardiovascular and other diseases contributing to morbidity and mortality among American Indians. In addition, morbidity and mortality surveillance of the original cohort continues. The investigators continue to analyze data from the previous three original cohort exams and the first family study exam. The *Strong Heart Study* has shown that diabetes is the number one risk factor for cardiovascular disease among American Indians. It has also shown that the effects of diabetes on cardiac structure and function begin early in adulthood. The large families available in the *Strong Heart Study* lend themselves to genetic analyses using advanced technology to better assess CVD risk factors. Tribal Consultation on data sharing policies is important to assess the use of this new technology. The next steps are to complete formal consultation between the NIH and the 13 tribes on important issues related to possible future research: data sharing requirements to be eligible for funding for *Genome Wide Association Study (GWAS).* In addition, dependent upon funding, phase VI of the *Strong Heart Study* will continue to assess the effects of fatty liver on cardiovascular disease risk.

Office of Research on Women's Health (ORWH) Family Cancer Literacy to Promote Mammography Screening among Navajo Women

This study proposes to develop a family-based cancer literacy intervention that includes culturally and linguistically appropriate education about breast cancer to promote mammography screening among Navajo women. Among American Indian and Alaska Native (AI/AN) women, breast cancer is more likely to be diagnosed at an advanced stage and the 5-year breast cancer survival rates are lower than any other ethnic group. Among Navajo women scheduled for a mammography screening appointment, the no show rate is markedly high (80%). The overall objective is to reduce breast cancer morbidity and mortality among Navajo women. This is a partnership between NIH, the Navajo Tribe and the Mayo Clinic in Rochester, MN.

ORWH Research to Improve Preconception Health of Adolescent Women

The Oglala Sioux Tribe, in partnership with Stanford Research/University of South Dakota School of Medicine and the Oglala Lakota College, will be addressing priority health issues identified by the tribe and to support and expand the research capacity and infrastructure that will build on the research foundation that has been developed within the tribe over the past decade. This initiative will help to train more Native American Researchers and Biomedical Professionals to increase the research capacity and infrastructure at tribal Colleges and Universities. This will lead to more research funding for Native Americans from the NIH. This will enhance the research foundation that has been developed within the Tribes over the past decade.

Office of Behavioral and Social Sciences Research (OBSSR) Building Bridges: Advancing American Indian/Alaska Native (AI/AN) Substance Abuse Research -- A State of the Science and Grant Development Workshop

This (NIDA) meeting which was co-funded by OBBSR, was held in October 2010. It targeted emerging AI/AN researchers and their tribal partners. The meeting showcased state-of-the-science AI/AN substance abuse research, identified future research needs, and provided both academic and tribal partners training and technical assistance in NIH grant writing and partnership development.

OBSSR *In-Home Prevention of Substance Abuse risks in Native Teen Families*

This NIDA-administered, OBSSR co-funded, randomized controlled trial will evaluate the effects of the *Family Spirit Intervention,* a prenatal/early childhood home visiting program to reduce maternal and child behavioral risks for lifetime drug abuse. The project serves White Mountain Apache, San Carlos Apache, and Navajo teen mothers from four Western US Indian reservations.

DIVISION SPECIFIC ACTIVITIES

9th Annual NIH American Indian and Alaska Native Heritage Month Program

Fogarty International Center (FIC) in collaboration with the NIH American Indian/Alaska Native Employee Council, and the NIH Office of Equal Opportunity and Diversity Management, co-sponsored a scientific speaker at the 9th Annual NIH American Indian and Alaska Native Heritage Month Program in November 2009. The speaker for the session was Patricia Nez Henderson, MD, MPH. She spoke on the topic "Indian Country Tobacco-free & Smoke-free Policy: The Navajo Experience." Dr. Henderson is Vice-President of the Black Hills Center for American Indian Health, a non-profit health organization in Rapid City, South Dakota. Dr. Henderson is a member of the Diné (Navajo) tribe.

National Institute of Dental and Craniofacial Research (NIDCR) Promoting Behavioral Change in American Indian Mothers and Children

Support will help the Center for Native Oral Health Research at the University of Colorado, Denver study several aspects of *Early Childhood Caries (ECC).* This randomized controlled trial will investigate the effectiveness of a behavioral intervention (motivational interviewing) on preventing ECC in a Northern Plains tribe. The intervention is being conducted in collaboration with the American Indian community to assure the development of culturally appropriate educational and health promotional materials that emphasize the value of family oral health from birth. In addition to understanding the effectiveness of this intervention on preventing ECC, the results of the study will provide an enhanced understanding of how this approach will influence moderators and mediators of the intervention. The specific caries patterns among participating American Indian children and costs of the program will be assessed.

NIDCR Prevention of Adult Caries (PACS)

This randomized, double-blind, multi-center, placebo-controlled, parallel group Phase III clinical trial is testing the efficacy of an antiseptic (chlorhexidine) dental coating, as compared to a placebo coating for reducing adult dental caries in at-risk adults over a 13-month observation period. Chlorhexidine coating will be tested on both root and coronal caries. One of the four centers contributing study participants is a dental clinic of a Native American Health Care Corporation.

NIDCR Streptococcus Mutans and Dental Caries in Native American Children

The objective of this prospective cohort study is to identify risk factors for early childhood caries *(ECC)* among infants and toddlers of a Northern Plains tribe and determine if the bacteria *Streptococcus mutans* alone, or in combination with environmental factors, increases the risk of ECC. This research project will provide valuable information on the acquisition of cariogenic bacteria in American Indian children. The investigators will determine the incidence of ECC through age 36 months and explore such issues as the transmission and virulence of *Streptococcus mutans* and the composition of total cultivable flora over time. In addition, the investigators will seek to identify behavioral, dietary and nutritional risk factors that may contribute to the disease.

NIDCR Booklet for American Indians and Alaska Natives

With the input of a Native graphic design team and input from parents, early childhood educators, health care providers, and community health educators from tribes in rural, urban and reservations settings, NIDCR adapted its "A Healthy Mouth for Your Baby" booklet for American Indian and Alaska Native audiences with the assistance of the University of Colorado Denver's Center for Native Oral Health Research. This easy-to-read publication addresses the importance of the primary dentition, teaches parents how to prevent early childhood tooth decay, and promotes the age one dental visit. The booklet is available on the NIDCR website.

NIMHD University of Oklahoma Center for American Indian Diabetes Health Disparities

This Center of Excellence focuses on maternal health, infant mortality, and obesity. Current studies include Early Markers of Pre-eclampsia in American Indians with Type 2 Diabetes, Insulin Resistance and Glucocorticoid Treatment of Inflammatory Diseases of High Prevalence among American Indians, and American Indian Diabetes Beliefs and Practices: Maternal Care, Infant Mortality, and Adherence. In addition, the Center is providing instruction and support for conducting practical research to address diabetes within their health care settings to a cadre of nurses from American Indian clinics and hospitals in Oklahoma and Kansas.

NIMHD Consortium for Community-Based Research in Native American Health

The purpose of this Center of Excellence is to develop a consortium that brings together researchers and communities to establish trust, share power, foster co-learning, enhance strengths and resources, build capacity, and examine and address community-identified needs and health problems. The ultimate outcomes of this project include the improvement in American Indian health and reduction of health disparities through enhanced health literacy, disease prevention behaviors, and increasing social capital in American Indian communities that ultimately leads to improved economic conditions.

NIMHD American Indian and Alaska Native Health Disparities

This Center of Excellence focuses on eliminating disparities across a broad range of health conditions in American Indian and Alaska Native populations. Current projects address: a) detection and management of depression in primary care, b) traditional healing practices to reduce risk of diabetes and cardiovascular disease, c) the availability of Medicaid insurance on patient outcomes and survival among cancer patients, d) the role of the physical environment in increasing physical activity levels and metabolic health outcomes, e) early psychosocial interventions for injury survivors at high risk of posttraumatic stress disorder, f) evidence-based follow-up of cancer survivors by tribal health care providers, g) the elevated risk of chronic liver disease, h)

communication of risk information on renal disease to patients with type 2 diabetes, i) implicit racial biases and stereotypes of primary care providers, and j) oral health prevention for young children.

NIMHD Central Plains Center for American Indian Health Disparities

This Center of Excellence has created an interdisciplinary platform for community-based participatory research (CBPR) on health disparities in American Indian communities in the Central Plains. The Center provides: 1) methodological support to health disparities researchers through biostatistics and data management; 2) fosters an educational pipeline for American Indian students from high school, through college, and into graduate schools in the health professions; and 3) conducts CBPR health disparities research. Current research subprojects include: An Assessment of American Indian Women's Mammography Experiences which is a mammography satisfaction project designed to determine how the mammography experience can be improved to encourage repeat mammography; and Tobacco Use among American Indian/Alaska Native Tribal College Students which is an epidemiology study focused on smoking patterns among tribal college students to help determine why American Indians have the highest smoking rates of any racial and ethnic group.

NIMHD Native Proverbs 31 Health Project

This project is part of the NIMHD Innovative Faith-based Approaches to Health Disparities Research Initiative. The purpose of the project is to develop, implement and evaluate a culturally appropriate cardiovascular disease (CVD) prevention program among Lumbee Indian women in Robeson County, NC, focusing on the biblical messages in Proverbs 31. The CVD intervention program will be implemented in four Lumbee Indian churches using a community health/lay health educator model that targets diet, physical activity and tobacco use.

NIMHD Elluam Tungiinun - Toward Wellness

This project is part of the NIMHD Community-Based Participatory Research Initiative. The project is implementing an intervention to address health disparities associated with alcohol use disorders and suicide among native Yupik youth in Alaska. The Elluam Tungiinun intervention was developed in collaboration with Yupik community members to reflect the cultural and local needs of the communities. The intended outcome of the intervention is to increase Yupik youths' reflective processes and enhance reasons for life so as to reduce and prevent alcohol use and suicide.

NIMHD Native Navigators and the Cancer Continuum

This project is part of the NIMHD Community-Based Participatory Research Initiative. The intervention being implemented addresses the cancer needs of American Indian communities throughout the continuum of care from screening to treatment. The intervention uses native navigators to educate American Indian communities about cancer and to provide support to those who have been diagnosed with cancer.

NIMHD Using CBPR to Implement Smoking Cessation in an Urban American Indian Community

This project is part of the NIMHD Community-Based Participatory Research Initiative. This project is implementing the All Nations Breath of Life intervention which is a culturally-tailored smoking cessation program. In addition to pharmacotherapy, the

intervention incorporates group counseling, telephone counseling, and education sessions so that it is effective in decreasing smoking among urban American Indians.

NIMHD Healing of the Canoe

This project is part of the NIMHD Community-Based Participatory Research Initiative. The Healing of the Canoe is a research project developed in collaboration with the Suquamish Tribe and University of Washington. This community-based intervention emphasizes cultural and community identity to address risk factors to prevent or reduce alcohol use and substance abuse among tribal youth.

NIMHD Child Safety Seat Intervention for Pacific Northwest Tribe

This project is part of the NIMHD Community-Based Participatory Research Initiative. The goal of this intervention is to increase child passenger restraint use in six northwest tribal communities. The multi-component intervention utilizes media campaigns, car seat clinics, advocacy for tribal seat law changes, and childcare and family worker child safety seat training to achieve the goal of preventing child death due to improper car restraint use.

NIMHD Impact of PCV on Disease and Colonization among Native American communities

American Indian tribes such as the Navajo and White Mountain Apache are much more likely to contract pneumococcal infections than those in the general U.S. population in spite of existing pneumococcal vaccines. The goal of this research study is to determine how PCV13, a new pneumococcal vaccine for infants, changes the types of pneumococcal strains moving throughout the American Indian community. The study involves an open-label observational study of PCV13 in 1100 adults and 2200 children, recruited from Indian Health Service pediatric clinics over a 2-year period.

NIMHD Using CBPR to Adapt a Culturally-grounded Prevention Curriculum for Urban American Indian Parents

The purpose of the study is to create and test a culturally-grounded parenting intervention for urban American Indian families through a modification of an existing prevention program, Families Preparing the Next Generation. The intervention will be adapted, piloted, evaluated, culturally validated, revised accordingly, and tested in a randomized control trial involving 600 families in partnership with the three largest urban Indian centers in Arizona. In addition to testing the intervention's impact, the research team will assess how the participants' connection to native culture and identity influences the interventions effects, and whether changes in overall family functioning lead to specific parenting practices directed at reducing their children's risk behaviors.

NIMHD Substance Use in Adolescent Reservation-Dwelling American Indians

This project is part of the NIMHD Health Disparities Research Loan Repayment Program. Research conducted within the scope of this project have included relevant personality measures to investigate the role that personality plays in the effects of alcohol use on smoking relapse. It tests hypotheses concerning how mood and alcohol, independently and in combination, influence the adolescent reservation-dwelling American Indian to smoke at predictable times and within specific contexts.

NIMHD Substance Abuse Health Disparities Research on Rural and Urban American Indians

This project is part of the NIMHD Health Disparities Research Loan Repayment Program. The primary objective of this research is to examine the role of ecological

stressors on the risk of substance abuse and long term mental and physical health for rural and urban American Indians. Determinants of substance abuse are considered and contributes to the design of culturally sensitive interventions, specifically through the integration of substance abuse treatment with both Western and traditional modalities in physical and behavioral milieus.

NIMHD Improving Cancer Outcomes for American Indians

This project is part of the NIMHD Health Disparities Research Loan Repayment Program. This project examines the causes for poor cancer survival in American Indians, a poorly understood phenomenon. Among the suggested causes identified as contributing to increased mortality in American Indians are difficulty with cost of care, the rural nature of many American Indian communities, systemic and cultural related causes for delayed diagnosis, and fatalism. Significant cultural and systemic barriers exist that may create an inhospitable setting for successful cancer treatment adherence.

NIMHD Neural Correlates of Food Reward in American Indian Women

This project is part of the NIMHD Clinical Research for Individuals from Disadvantaged Backgrounds Loan Repayment Program. This project which is a collaboration between University of Minnesota and all 11 federally-recognized American Indian tribes in Minnesota uses magnetic Resonance imaging to visualize brain activity patterns in response to images of fattening food, non-fattening food, and non-food objects to examine the correlation between brain response to food stimuli and obesity in American Indian women. It will provide data about brain activation in response to high-calorie foods in American Indian women that will inform dietary interventions aimed at using a pharmacologic treatment to prevent and treat obesity in this vulnerable population.

National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) Diabetes Based Science Education in Tribal Schools (DETS)

DETS involved Tribal Colleges and Universities (TCUs) to develop a culturally relevant curriculum for K-12 Tribal children with the NIDDK, IHS and CDC. DETS is 1) developing an understanding of diabetes, its complications and ways to reduce the risk of onset, 2) enhancing understanding of biomedical science and 3) encouraging Tribal children to enter health science professions. Measures to date indicate wide acceptance and strong teacher and student acceptance.

NIDDK Diabetes Mellitus Interagency Coordinating Committee (DMICC)

The DMICC, chaired by the NIDDK, and of which IHS is a member, helps facilitate coordination of federal diabetes research. In 1997, Congress established the Special Diabetes Program for Indians (SDPI), administered by IHS, to address the growing problem of diabetes in those communities. Participation as a DMICC member has provided IHS with valuable input for this important program. In addition, collaboration with NIDDK helped IHS to establish and implement targeted demonstration projects aimed at diabetes prevention and cardiovascular disease risk reduction in American Indian groups.

NIDDK National Diabetes Education Program (NDEP) Multicultural Campaigns

The NIDDK launched the NDEP with the CDC in 1997 to change the way diabetes is treated. Since its inception, NDEP has taken a multicultural approach to address its goals of improving diabetes management, approaches, community-based interventions, health system changes, and an inclusive partnership network. The project provides

ideas and encourages creation of activities in American Indian communities to provide education about diabetes prevention and treatment.

NIDDK Action for Health in Diabetes (Look AHEAD)

The purpose of Look AHEAD is to assess the long-term health impact of interventions designed to achieve and sustain weight loss over the long-term. Look AHEAD Clinical Trial includes a Southwest American Indian clinical center at the NIDDK Phoenix Epidemiology and Clinical Research Branch in Arizona. Look AHEAD began recruitment in 2001 and is scheduled to conclude in 2015. At baseline, the participants averaged 59 years of age and had a BMI of ~ 36 kg/m2. Thirty-seven percent of randomized participants were from racial/ethnic minority groups, including 5 percent American Indians.

NIDDK National Kidney Education Program (NKDEP)

NKDEP has worked to reduce the burden of Chronic Kidney Disease (CKD) and End-Stage Renal Disease (ESRD), especially among communities most impacted by the disease. ESRD disproportionately impacts racial and ethnic minorities, particularly African Americans, Hispanics, and Native Americans, and Native Americans are 1.8 times more like than whites to developed ESRD. The NKDEP Director serves as Chief Clinical Consultant in Nephrology for IHS, providing technical consultation and conducting educational activities for tribes and IHS on kidney disease and ESRD. In addition, the NKDEP Director conducts telenephrology clinics with the Zuni IHS facility. Since 2007, over 700 patients have visited the clinic. In collaboration with the IHS Diabetes Program, NIDDK has developed a range of materials on kidney disease adapted specifically for the AI/AN population and for the providers who serve the population.

National Library of Medicine (NLM) Environmental Health Information Partnership (EnHIP)

EnHIP strengthens institutional capacity to reduce health disparities through use of information technology and environmental health information. The program includes 3 Tribal Colleges, Oglala Lakota College (South Dakota), Diné College (Arizona), and Haskell Indian Nations University (Kansas); 14 HBCUs; 3 Hispanic-Serving Institutions, and the recently added University of Alaska, Anchorage, which serves a large population of Native Alaskans. This program has helped TCUs incorporate use of NLM resources in their curricula and in community outreach projects. Faculty, staff and students received training in NLM's information resources, and participated in meetings about scientific issues and funding opportunities. The program has also supported development of related local programs and projects.

NLM Create Health Information Resources & Technologies That Address Health Disparities

The activity is building population-specific, culturally and linguistically appropriate web sites that focus on issues of particular populations or geographic areas, as well as general consumer health web sites and print resources with information useful to health disparities. The American Indian Health (AIH) Web Portal (http://americanindianhealth.nlm.nih.gov) is a freely available information service dedicated to issues affecting the health and well-being of all North American Indians. The Arctic Health Web Site (www.arctichealth.org) is a collaborative effort between NLM and the Alaska Medical Library at the University of Alaska, Anchorage (UAA). The service brings together, in one location, reliable information on diverse aspects of the Arctic environment and the health of northern peoples.

NLM Chickasaw Health Information Center (CHIC)

CHIC (http://chicresources.net) is a public-private project jointly supported by NLM, the Chickasaw Nation, and Computercraft, a private science and technology company owned by a Chickasaw family. The CHIC is a consumer health information center in the Carl Albert Indian Health Facility in Ada, OK. Computercraft developed and hosts the CHIC website and also developed a mobile kiosk. NLM is presently training staff and health care providers and providing guidance about effective information provision practices. The CHIC will be moving to the Chickasaw Nation's new health facility where it will have a very public location.

NLM Native American Information Fellowship Program

The Native American Information Fellowship Program is teaching representatives from American Indian tribes, Native Alaskan villages, and the Native Hawaiian community about NLM. It also improves access to health information and health information technology for their communities. Fellows have been supported from the Mandan, Hidatsa and Arikara Nations (Three Affiliated Tribes), Ft. Berthold Reservation, North Dakota; the Nez Perce Tribe, Lapwai, Idaho; the Navajo Nation from Tuba City, Arizona; urban Indians; and three Native Hawaiians. Participants in the tribal fellowship program have implemented information access and use activities on their reservations or within their communities.

Office of Behavioral and Social Science Research (OBSSR) Native American Research Centers for Health (NARCH) V Program at the National Congress of American Indians Policy Research Center (NCAIPRC), University of New Mexico and University of Washington

This NARCH V focuses on promoters and barriers to community-based participatory research (CBPR) in American Indian/Alaska Native communities. The research study aims to: a) identify best practices, tools, and measurement instruments for use by partnerships nationwide; b) assess relationships between larger contexts, partnering relationships and intermediate CBPR outcomes (e.g., community capacities, policy/practice changes, sustainable and culturally-centered interventions) and c) identify variability of CBPR projects within diverse underserved communities. This multi-method study conducted through 2013 is jointly funded by the National Institutes of Health (NIH) and the Indian Health Service (IHS).

National Center for Research Resources (NCRR) Alaska Institutional Development Award (IDeA) Network of Biomedical Research Excellence (INBRE): Environmental Agents and Disease

The INBRE at the University of Alaska supports biomedical workforce training in Alaska. This training begins in high schools located in rural communities and remote Alaska Native villages. The INBRE also engages their parents and communities particularly in the villages. The program emphasizes pre-college programs for Alaska Natives and support for undergraduate research. The INBRE network includes students and faculty from lead and partner campuses, government laboratories, K-12 sites, tribal organizations and tribally-controlled health corporations. The *INBRE* funds student stipends for summer research experiences and other undergraduate research opportunities to build and support the pipeline leading toward health careers for Alaska Native students. The Alaska INBRE supports the Alaska Native Science and Engineering Program (ANSEP) to integrate outreach, recruitment, retention and placement strategies to promote success in college, and encourages graduate study.

ANSEP has increased retention rates of Native Americans in engineering programs (73 percent versus the national average of 27 percent).

NCRR Montana INBRE: A Multidisciplinary Research Network

The Montana INBRE supports student education to increase scientific and technical knowledge in the state's workforce and to develop community-based health research on Montana's Indian reservations to ultimately improve health in Native American communities. In Montana, seven Tribal colleges, including Little Big Horn, Chief Dull Knife, Blackfeet, Fort Belknap, Fort Peck, Salish Kootenai, and Stone Child are brought together under the IDeA Program to collaborate on biomedical research projects with undergraduate and research universities across the state. Over 20 students worked as interns on the project entitled: “Exposure Assessment to Environmental Contaminants on the Crow Reservation” at Little Big Horn College. Two additional NIH grants were developed and funded, in part, from the progress achieved by INBRE-funded projects.

NCRR Nebraska Research Network in Functional Genomics: The Little Priest Tribal College (LPTC)

The Little Priest Tribal College’s INBRE research project, “Aura Imaging, Iridology and Sclerology Research,” demonstrates the complexity of the human organism and the importance of the many homeostatic mechanisms that work in concert to give a person health and vitality. It provides interns with hands-on research experience equivalent to their education level and commensurate with their cultural experience; supports the students’ goals to pursue degrees in health-related fields and satisfies their desire to provide a service to the larger community of the Winnebago Tribe; and exposes the students to current technology and demonstrates an immediate, relevant, and practical application.

NCRR North Dakota INBRE: Health and the Environment

The North Dakota INBRE supports and expands efforts to engage Native American students in undergraduate research. It has established a genetics-based undergraduate-driven research program on pre-eclampsia at Turtle Mountain Community College into the Native American community. An introduction to research course has recently been developed by Native American faculty for the Cankdeska Cikana Community College. In addition, the North Dakota INBRE funded and stabilized the K-12 portion of the Indians into Medicine Program which produced over 25 percent of the Nation's Native American physicians.

NCRR Oklahoma INBRE

At the Harold Hamm Oklahoma Diabetes Center, researchers are investigating the genetic and environmental factors influencing 14 diabetes-related genetic traits in American Indian sibling pairs. The identification of genetic and environmental components of diabetes risk is necessary so that effective, culturally-appropriate intervention and treatment strategies can be developed. In addition, Comanche Nation Tribal College has used the Oklahoma INBRE to build its capacity to offer more STEM programming and to develop science coursework. The Comanche Nation College Science/Math classroom now is completed with new lab desks, lab stations, lab cabinets, lab equipment and 15 microscopes. These new additions have made a great impact on learning in the Biology class. Students are now able to perform more learning activities with these new additions and thus increase their knowledge in the fields of

Science. The total number of Science and Math students at Comanche Nation College during this time was 115.

National Eye Institute (NEI) Tohono O'odham Vision Screening Program

This project found that the visual disorder, astigmatism, is common among preschool Tohono O'odham children. Also, preschool children can be quickly and effectively screened for astigmatism using a keratometer, which can be used by non-medical personnel. This research underlies three major recommendations to assure proper care for children with astigmatism: 1) Every child should be screened by age 3 years. 2) A child with astigmatism should receive an eye examination to determine if eyeglasses are needed. 3) Arrangements need to be made for the child to receive eyeglasses, including a system for quick, easy, and inexpensive replacement (if needed).

National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS) The NIAMS Multicultural Outreach Initiative

The Multicultural Outreach Initiative helps to address disparities in accessing information about NIAMS disease areas among minority populations, including Native Americans. Its goals are to improve availability of research-based, culturally relevant information; emphasize that better health relies on research; and involve organizations and other agencies in NIAMS efforts. Four workgroups with diverse membership offer guidance in developing and disseminating messages and products for American Indians, Alaska Natives, Native Hawaiians, and Other Pacific Islanders; African Americans; Asian Americans; and Hispanics/Latinos. The group addressing Native American needs includes members who are affiliated with the Navajo Nation, Sioux, Kalamath Tribes of Oregon, Laguna Tribe in New Mexico, and Alaska Native communities.

NIAMS Understanding Rheumatic Disease in Oklahoma Tribal Members

As part of the Indian Health Service's NARCH program, NIAMS is supporting efforts by the Chickasaw Nation Health System to improve the health status of Native Americans who suffer from rheumatic diseases. Researchers are establishing the prevalence and overlap of rheumatic diseases in Oklahoma Tribal communities, defining the serologic and clinical features that characterize rheumatic diseases in Tribal members (compared with Americans of European or African descent) to improve disease diagnosis and clinical care for Native Americans, and providing medical care through the program's rheumatology clinics. The results of the study are pending.

National Institute of Nursing Research (NINR) Interactions Between Mothers and Their Premature American Indian Infant

This is a longitudinal study of the interactive behaviors of American Indian mothers and their premature infants from the Lumbee Tribe in Southeastern North Carolina. The study is exploring factors affecting mother-child interactions, including mothers' responses to having a premature infant in the Neonatal Intensive Care Unit (NICU) and their experiences in parenting their prematurely born children.

NINR Native Navigation Across the Cancer Continuum in Comanche Nation

This multidisciplinary project employs a community-based participatory approach to examine the use of trained individuals, "Native Navigators," to assist members of their tribe to navigate the health care system in order to receive needed education and services. The project will determine to what extent Native Navigator-initiated Native

American community education workshops improve knowledge regarding cancer prevention, screening, and treatment among Native American participants.

NHLBI We Can! Partnership with Cherokee Nation

We Can! is a national public education program to help prevent overweight among youth ages 8-13. In FY 2010, NHLBI and the Cherokee Nation continued to address various aspects of a Memorandum of Understanding (MOU) that began in April 2009. The MOU declared the Cherokee Nation as a We Can! (Ways to Enhance Children's Activity and Nutrition) Nation and was signed and supported by Chief Principal Chad Smith of the Cherokee Nation. The MOU continues to confirm the partnership between the We Can! program and Cherokee Nation. The MOU will utilize Cherokee Nation's communication channels to promote the We Can! message, integrate We Can! into the Cherokee Nation's existing health programs, and host training and technical assistance conferences on the We Can! for members of the Tribe. We Can! reaches parents and caregivers in home and community settings with educational materials and activities to encourage healthy eating, increase physical activity, and reduce screen time. As a result of the MOU, in February 2010, the Cherokee Nation served as reviewers for an American Indian, We Can! article focusing on the impact of overweight and obesity within the American Indian communities. The article was then widely distributed nationwide through various mechanisms (newsletters, listserves, websites, etc.). As a result of the partnership between NHLBI and the Cherokee Nation Healthy Nation (Community Health Department), ten schools within the Cherokee Nation began to implement at least one of the following youth based curricula, CATCH and SPARK, which are part of the overall We Can! program.

NHLBI Arsenic Exposure, Cardiovascular Disease and Diabetes in Native Americans

The objective is to evaluate the association of inorganic arsenic exposure, as determined by the sum of inorganic and methylated arsenic species in urine, and arsenic biotransformation with the risk of cardiovascular disease and diabetes in 4,549 Native Americans who participated in the Strong Heart Study. A total of 1,168 urine samples have been analyzed for urine arsenic species (arsenite, arsenate, methylarsonate (MA), dimethylarsinate (DMA) and arsenobetaine), total arsenic and the following metals: antimony, cadmium, lead, molybdenum, selenium, tungsten and zinc. An initial analysis showed low to moderate inorganic arsenic exposure and confirmed long-term constancy in arsenic exposure and urine excretion patterns in American Indians from three U.S. regions over a 10-year period. Further analysis of 600 samples is in progress to correlate arsenic exposure and cardiovascular and pulmonary health.

NHLBI Tribal College Faculty and Tribal Health Professionals Development Project

This study will increase the capacity in basic epidemiology research among tribal college or university faculty and tribal health professionals. The study will develop and conduct skill-building workshops to enhance research capacity. These skills will be immediately applicable to their current positions in the health field. Begun in FY 2010, the project is building capacity among the tribal college faculty and tribal health professionals working in health research and other health fields and also fostering relationships between academic institutions and tribal communities.

NHLBI Prevalence of Congenital Heart Disease in Native Americans in Wisconsin

Congenital heart disease is the most common birth defect encountered in Wisconsin and there is evidence that the incidence may be nearly twice the expected rate in Native

Americans. Initiated in FY 2010, the study will determine the actual rate of congenital heart disease in Native Americans in Wisconsin and will identify possible risk factors.

National Institute on Alcohol Abuse and Alcoholism (NIAAA) Prenatal Alcohol Consumption among Native American Women in San Diego County

Fetal Alcohol Spectrum Disorders (FASD), a totally preventive congenital child health condition, is a health disparity concern for American Indian communities. Within the Indian Health Services' Native American Research Centers on Health program, San Diego State University established a partnership with the Indian Health Centers of the Southern California Mission Indian Tribes. This group will culturally adapt and test two different Screening, Brief Intervention and Referral for Treatment programs for implementation among American Indian women of reproductive age. American Indian health professionals will be trained to conduct the research and transfer the research findings to practice in their clinics.

National Institute of General Medical Sciences Bridges to the Baccalaureate Program

The Bridges to the Baccalaureate program makes available to the biomedical science research enterprise and to the nation the intellectual talents of an increasing number of underrepresented groups by facilitating the transition of students from associate-to baccalaureate-degree granting institutions. The program promotes effective inter-institutional partnerships that lead to improvement in the quality and quantity of underrepresented students being trained as the next generation of scientists. Bridges provides laboratory research experiences, mentoring and academic counseling programs, curriculum enrichment, visiting lectureships, and course development.

NIGMS Research and Academic Career Development Award (IRACDA)

IRACDA combines a traditional, mentored postdoctoral research experience with an opportunity to develop teaching skills through mentored assignments at a minority-serving institution (MSI). The program serves as a resource to motivate the next generation of scientists and to promote linkages between research-intensive institutions and institutions, which support a number of students from underrepresented populations.

NIGMS Research Initiative for Scientific Enhancement (RISE)

RISE supports faculty and student development activities, which can include on-campus or off-campus workshops, specialty courses, travel to scientific meetings, research experiences at on-campus or off-campus laboratories, and evaluation activities. RISE also offers some support for institutional development, which includes limited funds for the renovation or remodeling of existing facilities to provide space for an investigator to carry out developmental activities, limited equipment purchases, and the development of research courses. Current RISE tribal support has been given to Haskell Indian Nations University and Salish Kootenai College.

National Institute on Drug Abuse (NIDA) NIDA Goes to School Information Dissemination

NIDA Goes to School materials were disseminated to 50 tribal high schools, Mar 2010.

NIDA Students Supported to Attend Research Institute

NIDA provided support for an American Indian student to attend the Johns Hopkins Center for American Indian Health Winter Institute (January 2010). NIDA also provided support for five students to attend a drug abuse epidemiology course at the Northwest Portland Area Indian Health Board Summer Research Training Institute for American

Indian/Alaskan Native (AI/AN) Health Professionals. Goals of this activity included promoting pipeline of investigators, increasing technical assistance, and increasing NIDA accessibility.

NIDA Acceptability of a Web-delivered, Evidence-based, Psychosocial Intervention among Individuals with Substance Use Disorders who Identify as American Indian/Alaska Native

In March 2010, work began on this feasibility study conducted by the NIDA Clinical Trials Network (CTN). The principal objective of the planned trial is to explore the acceptability of an interactive, web-based version of the Community Reinforcement Approach (CRA) intervention among a non-representative, but diverse sample of AI/AN enrolled in outpatient substance abuse treatment. The study will be conducted in two community treatment programs (CTPs) that primarily treat AI/AN clients in Portland, OR and Rapid City, SD. The primary outcome of this study will be the acceptability of the web-based intervention.

NIDA American Indian/Alaska Native Coordinating Committee Seminar Series

To increase staff knowledge of AI/AN research and to provide outreach to investigators, NIDA sponsored in April 2010, two NIH seminars focused on AI/AN drug abuse research. The first was titled “Adapting Evidence-Based Treatment with American Indian/Alaska Natives” and the second was “In Home Prevention of Drug Abuse in Native American Teen Families: Baseline Characteristics and Preliminary Outcomes.”

NIDA CBPR with Tribal Colleges-Universities: Alcohol Problems-Solutions

This project will use Community-Based Participatory Research methods to conduct the first investigation of Alcohol, Drug and Mental Disorders (ADM) at Tribal colleges or universities (TCU) and is a preliminary step on a path toward developing culturally appropriate and sustainable interventions at TCU.

NIDA Caring for Our Generations: Supporting Native Mothers and Their Families

A 4-year developmental project to explore maternal health behaviors, maternal substance use, risk factors for substance use during and after pregnancy, and protective factors that support healthy maternal behaviors.

NIDA Native Pathways to Sobriety: Pacific Northwest Oral Life Histories

Alcohol and drug abuse and dependence represent major problems for AI/AN individuals and their communities. The present studies will provide insights into resiliency and recovery factors and inform the development of prevention and treatment strategies.

NIDA Tobacco Cessation Treatment for Alaska Native Youth

This study proposes to develop a behavioral intervention for tobacco cessation that is culturally appropriate for youth of the Yukon-Kuskokwim (Y-K) Delta region. Developing effective tobacco cessation interventions for Alaska Native youth may ultimately reduce their risk of cancer and other tobacco-related disease.

NIDA Factors Related to Substance use Development in Young American Indian Adolescent

This study focuses on understanding emergent substance use among young adolescent American Indians and identifying risk and protective factors that may provide windows of opportunity for prevention.

NIDA Community Trial in Alaska to Prevent Youth's Use of Legal Products to Get High

This efficacy trial will integrate quantitative methods with community participation the unique cultural heritage of each study community. The significance of this study is its potential to produce an intervention to prevent youth's use of inhalants and other harmful legal products in remote rural and sustainable communities across the U.S.

National Human Genome Research Institute (NHGRI) Center for Genomics and Healthcare Equality

A Program Project Center Grant from the NHGRI supports this research Center at the University of Washington in Seattle, Washington, whose mission is to explore the implications of genomics for medically underserved communities—particularly American Indian and Alaska Native communities. Center investigators have developed collaborative relationships with three American Indian/Alaska Native tribal organizations and with a research center dedicated to Alaska Native health concerns.

NHGRI Indigenous Communities and Human Microbiome Research

This project investigates the implications of research on ancient and contemporary human microbiomes for the social and ancestral identities of indigenous people. As part of the study, community members take part in focus groups, individual survey interviews, and public meetings to discuss the ways in which local variations in human microbiomes are related to differences in environment, lifestyle and culture may have implications for health disparities, population histories, and social and ancestral identities.

NHGRI PAGE (Population Architecture of Genes and Environment)

PAGE is a collaborative study examining well-phenotyped, population-based, and ethnically diverse cohorts involving >80,000 participants. The study aims to assess generalizeability across diverse ethnic groups and examine associations across important phenotypes and identify genetic and environmental modifiers. 7,000 participants are from 13 American Indian tribes: Apache, Caddo, Comanche, Delaware, Fort Sill Apache, Kiowa, Wichita, Gila River and Salt River Pima/Maricopa, Akchin Pima/Papago, Oglala Sioux, Cheyenne River Sioux, and Spirit Lake Communities. Additionally, 388 AI/AN participants are from the Women's Health Initiative. Data from the PAGE study are currently being analyzed in relation to heart disease, diabetes, obesity and lipids.

NHGRI National Congress of the American Indian (NCAI) Roundtable Meeting

NHGRI Director and staff met with the NCAI's Policy Research Center Board of Directors and staff to begin a dialogue between the NHGRI and the Policy Research Center at the NCAI, regarding genomics and health and the ethical, legal and social implications for American Indian communities. Following the roundtable meeting, a plenary session and concurrent session entitled "Exploring the Crossroads between Genetics and Health Priorities in American Indian/Alaska Native Communities" was presented at the NCAI meeting in Rapid City, SD, on June 20-23, 2010.

NHGRI Washington Internship for Native Students (WINS) Summer Program

In an effort to recruit individuals of American Indian, Alaska Native and Native Hawaiian descent into the NIH Summer Internship Program, the NHGRI Intramural Training Office (ITO) sponsored a summer student from American University's Washington Internships for Native Students (WINS) program for the summer of 2010. This is the second year

that NHGRI has participated in the WINS program. The 2010 summer intern worked in an NHGRI Senior Research Investigator's lab.

NHGRI Community Genetics Forum

NHGRI sponsors annual community genetics forums aimed at developing model engagement activities around the country. The 2010 Forum was held in Salt Lake City and two Native American communities were directly included in the planning. The Forum brought together approximately 400 people in conversation around genomics and health, specifically related to heart disease, cancer, and diabetes. At the 2010 American Public Health Association, the American Indian Walk In Center presented its experience in the Community Genetics Forum Program.

National Cancer Institute (NCI) Alaska Native Tumor Registry

In 2010, NCI's Surveillance, Epidemiology, and End Results (SEER) Program continues to include the Alaska Native Tumor Registry (ANTR) as a full member through an interagency agreement with the Alaska Native Tribal Consortium. In 1999, the ANTR completed its first survival analysis, which was distributed statewide to medical providers, tribal health board members, and key tribal personnel. The ANTR published "Cancer in Alaska Natives 1969–2003: 35-Year Report" in 2006. ANTR currently submits data annually to SEER in November.

NCI Cherokee Nation Cancer Registry (CNCR)

NCI's Surveillance Research Program is partnering with the Cherokee Nation of Oklahoma to fund a pilot cancer registry that conforms to SEER standards in case finding, patient follow-up, data processing, data reporting, and quality assurance. The target population includes all American Indians residing in the Cherokee Nation's 14-county tribal jurisdictional service area in Oklahoma. CNCR data were used to obtain funding from the Center for Disease Control and Prevention (CDC) for the Cherokee Nation Comprehensive Cancer Control Program. In 2010, data from CNCR has been submitted, for the first time, to NCI using the new SEER data management system.

NCI Northwest Portland Tribal Registry Project

The Northwest Portland Area Indian Health Board is a tribal organization governed by the 43 federally recognized tribes of Idaho, Oregon, and Washington. The Northwest Tribal Registry (NTR) Project was formed by the Board to increase the quality of surveillance data on AI/AN through record linkage studies. NTR is maintained and regularly updated by through NCI support. Some subpopulations of AI/AN who have not accessed care through the IHS are under-represented in the registry, most notably those living in urban areas. In 2010, a partnership with the Seattle Indian Health Board enabled NTR to supplement its data with the AI/AN patient registry of the area's largest urban Indian health clinic.

NCI Native American Research Centers for Health (NARCH)

The NCI is committed to reducing cancer health disparities among American Indians and Alaska Natives (AI/AN) through the NARCH initiative. Research projects funded through this initiative will increase research capacity of AI/AN research institutions and provide much needed outreach to address observed cancer health disparities in the AI/AN communities. NARCH continues to carry out research projects that are relevant to the needs of specific tribes in the AI/AN communities to increase awareness about cancer screening, diagnosis and treatment in order to reduce cancer health disparities among

AI/AN. Three NCI-supported NARCH projects are increasing the number of AI undergraduates exposed to biomedical research opportunities and promoting early detection of cervical cancer through HPV self-sampling.

NCI Oklahoma NARCH Student Development Project

This NARCH student development program is recruiting undergraduate students from Cherokee, Chickasaw, Choctaw, Creek, and Seminole tribes in Oklahoma, into the Summer Undergraduate Research Program at the University of Oklahoma Health Sciences Center (OUHSC). Undergraduate students will conduct research, participate in workshops and receive tutoring and counseling about the graduate and professional school admissions processes. This Project seeks to increase the number of American Indian undergraduate students exposed to Biomedical Research Opportunities at a Research Intensive Institutions.

NCI NARCH VI Administrative Core-Lakota Center for Health Research

The major goals of the proposed administrative core is to coordinate the activities of NARCH VI, including monitoring of training of students and research projects, programmatic decisions, data analysis and planning/review over a wide geographical range and multiple institutions. To accomplish these goals, the Black Hills Center for American Indian Health (BHCAIH) will partner with the South Dakota School of Mines and Technology (SDSMT)), the white House Initiative on Tribal Colleges and Universities (TCUs) and carry out three research projects and one student development training project. These efforts will help in developing a cadre of AI/ANs actively engaged in environment related health inequities research.

NCI Northern Plains NARCH Program: HPV Self-Sampling to Improve Cervical Cancer screening in AI Communities

Studies have shown that the overall survival and mortality rates of cervical cancer patients may significantly improve (up to 92%) if the cancer is diagnosed at the preneoplastic or early neoplastic lesion stage. CRCHD maintains funding of this high impact study involving cervical cancer screening in American Indian communities. This study will entail HPV self-sampling to improve cervical cancer screening in American Indian Communities in the Aberdeen area of South Dakota. This study has potential to lead to increased early detection of cervical cancer, which may improve patient management and reduce cervical cancer mortality in this population.

NCI University of Arizona and Northern Arizona Partnership - Study of Uranium as an Environmental Risk Factor for Cancer among the Navajo

This joint project of the University of Arizona and Northern Arizona University seeks to: 1) identify organic uranium complexes and determining uranium isotope ratios in unregulated water sources; 2) measure the extent of uranium contamination of soils from the abandoned mines in remediation areas of Navajo lands; and, 3) test the bioavailability and mutagenicity of natural uranium using model systems. To date water samples from 29 wells and over 350 soil samples in the study area have been collected. Analyses of these samples are ongoing. Although the scientific link between uranium and human health is unclear, the perception of the Navajo people is that uranium has poisoned many in their community. These studies are a critical first step in an interdisciplinary approach aimed at empowering Native Americans to address their concerns over environmental exposure to uranium. The project will also train

undergraduate and graduate Navajo students at the University of Arizona and Northern Arizona University.

NCI Southwest American Indian Collaborative Network (SAICN)

The NCI provided support for the Inter Tribal Council of Arizona to establish the SAICN to eliminate cancer health disparities among American Indians. This collaborative project involves three primary partners: the Inter Tribal Council of Arizona, Inc. (ITCA), the Arizona Cancer Center (AZCC), and the Phoenix Indian Medical Center (PIMC), with input from the communities, the three Arizona universities, and genomics researchers from the Translational Genomics Institute (TGen). The organizational infrastructure, made up of six core services, has been implemented in order to support community-based participatory activities and the development of partnerships among communities, cancer prevention/care delivery systems, and research discovery/development systems. The cores were established and fully staffed during the first year of SAICN. The SAICN cores are: Administrative, Data and Evaluation, Outreach and Service, Policy, Research, Training and Education. The cores are designed to help assure that this occurs at many levels, thus allowing SAICN to increase and sustain delivery of interventions and to develop pilot studies using a collaborative approach. NCI plans to continue the development of interventions and work with the Inter-Tribal Council of Arizona, Inc., and other partners to reduce cancer health disparities in the Native American population.

National Institute on Aging (NIA) Native Elder Research Center (NERC) Program of the Resource Centers on Minority Aging Research (RCMAR)

The University of Colorado at Denver and Health Sciences Center's Native Elder Research Center is a NIA RCMAR. Aims include expanding partnerships with AI/AN/NA communities insuring continuous access and involvement of Native elders, their families, and local systems of care in the aging research process, and preparing AI/AN/NA investigators for research careers at the interface of aging, health, and culture and for reducing differentials in health status. The 2010 -2012 cohort of Native investigators include: Kelly Gonzales, PhD (discrimination); Emily Haozous, PhD, RN (SEER data); Michelle M. Jacob, PhD (diabetes); Nichea Spillane, PhD (smoking cessation); and Gayle Morse, PhD (TBD).

NIA Telecognitive Assessment: Extending Neuropsychology to Underserved Elders

This study will a) determine the reliability of videoconference (VC) -based neuropsychological testing in older adults with and without cognitive impairment by comparing videoconference testing with traditional face-to-face assessments; and b) examine the feasibility and reliability of telecognitive testing in a population of rural Native American elders

National Institute of Allergy and Infectious Diseases (NIAID) Viral Host Interactions in Hepatitis C

This study of hepatitis C virus infection long-term clinical outcomes is ongoing in a large cohort of Alaska Natives and American Indians. Associations with disease, duration of infection, and genotype have been identified for the first time in a population of this size and relative homogeneity. The paper “Adverse outcomes in Alaska Natives who recovered from or have chronic hepatitis C infection” was published by Gastroenterology in November 2009 and “Factors associated with the progression of fibrosis on liver biopsy in Alaska Native and American Indian persons with chronic hepatitis C” is in press at the Canadian Journal of Gastroenterology, McMahon BJ, Bruden D, Bruce MG,

Livingston S, Christensen C, Homan C, Hennessy TW, Williams J, Sullivan D, Rosen HR, Gretch D. Adverse outcomes in Alaska Natives who recovered from or have chronic hepatitis C infection. Gastroenterology, 138(3):922-31.e1. Epub 2009 Nov 10.

NIAID Arthritis and Autoimmunity in Chronic Hepatitis C Virus Infection

This is a pilot study proposed to define the clinical and laboratory features of hepatitis C virus-associated (HCV-associated) arthritis and the implications of HCV-associated autoimmunity in an existing population-based prospective cohort of Alaska Native/American Indian (AN/A)I individuals. The specific aims for this project include basic and clinical research in a cohort of Alaska Native/American Indian people with chronic HCV infection and to determine the prevalence and associations between arthritis-related autoantibodies, musculoskeletal symptoms, and autoimmunity.

TRIBAL DELEGATION MEETINGS

HHS 12th Annual National Tribal Budget Consultation (ATBC), scheduled on March 3 – 5 at the Hubert Humphrey Bldg. in Washington, DC

The NIDDK provided a staff member to represent the NIH at the HHS Tribal Budget and Policy Resource day held the second day of the 12th ATBC in 2010). Presentation was made to the Breakout Session focusing on HHS research activities. NIDDK-supported American Indian research activities were reviewed and research opportunities reviewed.

NIDDK HHS Region 8 Tribal Consultation

NIDDK representative was present and participated in discussions relating to Tribal open dialogue and NIDDK collaborative participation with Tribal Colleges and Universities, Tribal participation in clinical trials and Tribal involvement in the translation of improved diabetes clinical care and prevention.

NIAMS Director's Visit with Leaders of the South Central Foundation and the Alaska Native Tribal Health Consortium at the Alaska Native Medical Center, Anchorage

In October 2010, the NIAMS Director met with leaders of the South Central Foundation and the Alaska Native Tribal Health Consortium. Both are Native-owned, nonprofit health care organizations serving Alaska Native and American Indian people in Alaska. He delivered a medical grand rounds lecture at the Alaska Native Medical Center, and distributed information about NIH research and NIAMS health promotion materials. NIAMS will continue to foster relationships established through this visit as it develops messages through its Multicultural Outreach Initiative and disseminates materials through the Trans-NIH American Indian and Alaska Native Health Communications and Information Workgroup.

National Institute of Mental Health (NIMH) Southcentral Foundation Consultation Visits NIMH

On March 22, 2010, Ted Mala, M.D., M.P.H.—Director of Tribal Relations and Traditional Healing, Alaska Native Medical Center, Southcentral Foundation, Anchorage, Alaska—visited NIMH. Douglas Eby, M.D., M.P.H., Medical Services Vice President, Katherine Gottlieb, M.B.A., President/CEO, and Kevin Gottlieb, D.D.S. Vice President/Chief of Staff also attended. Pamela Y. Collins, M.D., M.P.H., Director of the Office for Research on Disparities and Global Mental Health and the Office of Rural Mental Health Research, led NIMH participants. The delegation described its tribal-based intervention, "Family Wellness Warriors," for survivors and perpetrators of family violence. NIMH encouraged intervention evaluation, and plans collaborative program advancement.

AMERICAN RECOVERY AND REINVESTMENT ACT ACTIVITIES SPECIFIC TO THE TRIBES

National Nursing Institute (NINR) Building a Sustainable Indian Tribal Infrastructure for Translational Research

This ARRA-supported project seeks to establish a partnership infrastructure between an academic health center and rural tribes to enhance tribal capacity to engage in behavioral science and translational research. The program draws upon social learning theory, employing a community-based participatory research approach to assist the tribes in conceptualizing, planning, and submitting evidenced-based translational research grants for their communities.

NINDS Alaska Native Stroke Registry

ARRA-funded supplements were provided to the Alaska Native Stroke Registry to support urban sampling and rural door-to-door case ascertainment activities to better understand attitudes and beliefs about vascular risk factors for developing a primary risk reduction trial. The investigators developed a survey instrument to assess stroke and myocardial infarction, vascular risk factors, medication adherence, social health networks, community social organization, health-illness beliefs, explanatory models of disease, health locus of control, and barriers to physical activity. This survey, in combination with information from the parent project, will guide development and implementation of a culturally tailored stroke prevention intervention.

NIDDK ARRA Supplements to Diabetes-Based Science Education in Tribal Schools (DETS) participating Tribal Colleges and Universities

Tribal Colleges and Universities participating in the DETS program received supplemental funding to support new and expanded K-12 curriculum dissemination and school implementation activities.

National Institute of Dental and Craniofacial Research (NIDCR) ARRA funded Summer Student Research Award

An award was made with Recovery Act funds for a summer student research initiative at the University of Colorado Denver's Center for Native Oral Health Research. The initiative gave two dental student experiences working with a Native American community on research projects underway. One of the two students is Native American.

National Institute on Minority Health and Health Disparities (NIMHD) Addressing Diabetes/CVD Health Disparities among American Indians: A Transdisciplinary Approach

This project is part of the NIMHD Social Determinants of Health Initiative. The purpose of the project is to assess the viability and sustainability of an intervention utilizing two electronic tools: 1) one for increasing exercise and 2) one for tracking diet and exercise among overweight/obese American Indian/Alaska Natives living in urban areas. The project seeks to: 1) determine whether introduction of electronic devices leads to decreased risk for diabetes and cardiovascular disease; 2) assess the social determinants of resultant changes in diabetes and cardiovascular disease risk using sociobehavioral theories; and 3) place the investigations of effectiveness in a larger translational framework by exploring aspects of reach, adoption, and implementation in order to understand issues of viability and sustainability of this and comparable interventions.

NIMHD HOPE Accounts for Women

This project is part of the NIH Challenge Grants Initiative. The purpose of the project is to develop an innovative intervention approach to address obesity among low-income minority women in rural North Carolina. Individual Development Accounts (IDA) which are matched savings accounts for low-income individuals provide financial assistance for a microenterprise, further education, or home ownership. The proposed intervention aims to improve health among low-income minority women by providing financial support through IDAs in conjunction with information and social support needed to pursue financial and health goals.

NIMHD Native Youth Enrichment Program for STEM Career Pathways

This project is part of the NIH Challenge Grants Initiative. This project establishes Native Youth Enrichment Program (NYEP) which is an innovative, culturally-based 4-week summer intensive Science, Technology, Education, and Mathematics (STEM) career path program targeting American Indian Youth in 7th through 10th grades. The NYEP engages STEM partners and teachers in designing and developing age-appropriate curricula, mentored student projects, field trips, and exposure to American Indian STEM role models and career paths. It also establishes a STEM buddy program between the NYEP participants and University of Washington.

NHLBI Collaboration between the Cherokee Nation and the Oklahoma Department of Health to implement We Can!

ARRA funds from the HHS Communities Putting Prevention To Work Program were awarded to the Cherokee Nation and, State Set-Aside ARRA funds to the Oklahoma Department of Health. To tackle the burden of obesity, the Cherokee Nation will develop local media strategies to promote healthy food and beverage choices; limit unhealthy food and beverage availability in schools; implement farm-to-school programs; adopt quality physical education in schools; increase safe, attractive, and accessible places for physical activity; adopt procurement and purchasing policies to reduce the price of healthy foods; develop prompts for healthy food and beverage items and implement menu labeling; reduce the cost of recreation services; and expand activity groups in workplaces, community gathering places, parks, and neighborhoods. In September 2010, as part of the ARRA funding, the Cherokee Nation Health Service Group began discussions with the Oklahoma State Health Department, who also received ARRA funding, to partner on We Can! focused activities, specifically in the area of We Can! Parent Program training. Planning for the training is currently taking place. NHLBI will assist to facilitate the trainings and provide technical assistance as these activities develop.

National Institute on Drug Abuse (NIDA) Partnership for Public Health Research in the Oglala Sioux Tribe

The Oglala Sioux Tribe faces numerous health challenges, many of which are related to behaviors that emerge during childhood and adolescence. This project will solidify the partnership between Centers for American Indian and Alaska Native Health at the University of Colorado Denver and the Tribe's Health Administration, taking concrete steps to build research infrastructure within the Tribe, with a likely focus on prevention activities among the Tribe's youth. It will usher in a new phase in community-based participatory research for health in this community and set a precedent for the development of tribal participation in research in other AI/AN communities.

National Cancer Institute (NCI) National Outreach Network (NON) Community Health Educators (CHE) Initiative

ARRA funding provided the opportunity for the NCI National Outreach Network to fund a position for a CHE at the Native People for Cancer Control (NPCC), under the auspices of the University of Washington. The National Outreach Network seeks to build and sustain a network for education, outreach and research dissemination in at-risk and underrepresented communities by funding CHEs at key grantee sites. NPCC focuses on prevention, screening and detection, treatment and survivorship by enhancing existing relationships and programs and fosters partnerships to improve education, training, and research. The NCI will continue the development of interventions for Native Americans in the Northwest to increase awareness of cancer risks and importance of early detection. This program, uses community-based participatory (CBPR) methods in an integrated, stepwise strategy to: (1) increase cancer education activities among American Indians and Alaska Natives; (2) build the capacity of Tribal colleges and universities to become partners and leaders in cancer-related investigation and dissemination efforts; (3) enhance training opportunities for Native researchers; (4) conduct community-based research on access to care, health promotion, and disease prevention activities targeting key cancer disparity issues; and (5) reduce cancer-related health disparities by increasing access to and use of feasible interventions. Community Outreach Network partners include Alaska Native Health Consortium, Arctic Slope Native Association, Rocky Mountain Tribal Epidemiology Center, Seattle Indian Health Board, and the Indian Health Service (IHS). Accomplishments include: 1) presenting "Digital Storytelling for Community Outreach" at the Puyallup Tribal Health Authority Annual Meeting; 2) helping to plan, implement, evaluate and present at several South Puget Intertribal Planning Agency sponsored events, such as the Men's Wellness Summit, the Cancer Survivor Summit and the Youth Cancer Prevention Conference; 3) updating Understanding Cancer curriculum with new chapters on genetics, survivorship and palliative care, developed in a culturally-sensitive manner for the American Indian population; and, 4) publishing "Telehealth for Cancer Support Groups in Rural American Indian/Alaska Native Communities" in the Clinical Journal of Oncology Nursing.

National Human Genome Research Institute (NHGRI) Engaging Tribal Participation in Research Through Priority Setting And Regulation

NHGRI distributed ARRA funding to support this research project at the University of Washington in Seattle, WA. The study will develop, implement and document processes to increase Tribal participation in research by identifying health research priorities and a research regulation process that reflects the priorities and concerns of Tribal communities. The Squaxin Island Tribe is participating in this study. Researchers will elicit Tribal community members' priorities for health interventions and research; assess their knowledge, attitudes, and willingness to participate in research; and engage Tribal leadership and community advisors to develop a research oversight and regulatory process.

National Institute of General Medical Science (NIGMS) NIGMS Administrative Supplements to Bridges grants.

Bridges to the Baccalaureate programs are designed to improve the quality and quantity of students from underrepresented groups and health disparities populations being trained as the next generation of biomedical research scientists. Bridges programs are aimed at helping students make the transition from 2-year junior or community colleges to full 4-year baccalaureate programs. Through ARRA grant support, NIGMS

has awarded seven administrative supplements for Bridges to Baccalaureate programs which strengthen partnerships between research institutions and community colleges.

TRIBAL DELEGATION MEETINGS

National Library of Medicine (NLM) Workgroup Meeting for NLM Exhibition Program on Native American Concepts of Health and Illness

NLM convened a workgroup meeting with representation from varied tribes on September 29-30, 2010, at NLM to obtain advice on the scope, content, and implementation of the planned NLM exhibition on "Native American Concepts of Health and Illness." Participants included American Indians, Alaska Natives, and Native Hawaiians drawn from tribal and Western medical, health, and cultural leaders. Participants discussed a variety of ideas, topics, and perspectives for possible use in the exhibition. Additional meetings may be scheduled for FY2011.

National Cancer Institute (NCI) Eighth National Conference on Changing Patterns of Cancer in Native Communities: "Strength through Tradition and Science"

NCI supported the Eighth National Conference on Changing Patterns of Cancer in Native Communities with the theme of "Strength through Tradition and Science," on September 11-14, 2010, at The Westin Hotel in Seattle, WA. The conference was convened by the Spirit of Eagles, a research program based at the Mayo Clinic, and funded by NCI. The intended audience for this conference included community members and leaders, survivors, advocates, researchers, health care providers, policy makers, and others working with Native populations – American Indians and Alaska Natives.

NCI and NIDCR Support 22nd Annual Native Health Research Conference

The 22nd Annual Native Health Research Conference, (July 27-30, 2010 – Rapid City, South Dakota) was themed "Translating Research into Policy and Practice in Native Health" and included as attendees researchers, health care providers, administrators, educators, Tribal Review Board members, indigenous students in training, policy-makers, and tribal leaders who conduct or are involved with health research in Native American communities. The purpose was to enhance the ability to advance biomedical, behavioral, and health services research for the benefit of Native communities, as well as to showcase recent health research projects and efforts undertaken in Indian Country.

NCI provided support for the conference and conducted a workshop at the conference on community-based participatory research. The program also included an overview of the NIDCR's Health Disparities Research Program and funding opportunities with a presentation by a Native American Research Centers for Health (NARCH) grantee. In addition, an oral health panel supported by the NIDCR was convened by the University of Colorado Denver's Center for Native Oral Health Research that focused on varied aspects of the conduct of oral health research with American Indians from the perspectives of a researcher, dentist, dental student, community member and institutional review board **(**IRB) chair – all of whom are Native American.

NIDA Participation in HHS Tribal Budget and Policy Consultation Session

NIDA staff participated in the NIH breakout session at the HHS Tribal Budget and Policy Consultation Session, Washington, DC (March 4-5, 2010).

NIDA Participation and presentation in the HHS Region V Bemidji Area Tribal Budget and Policy Consultation Session

NIDA staff participated in and presented at the HHS Region V Tribal Budget and Policy Consultation session in Minneapolis, MN (April 20, 2010). Staff described past, current and future initiatives, accomplishments and activities and heard tribal leaders present their research priorities and concerns related to substance abuse research.

NIDA American Indian/Alaska Native Mentoring Program at the 2010 Blending Addiction Science and Practice Conference, Albuquerque, New Mexico April 22-23, 2010.

Fourteen individuals were selected to participate in the mentoring program that provided technical assistance for grant development, seeded relationships, increased NIDA accessibility for AI/AN researchers/communities.

NIDA Support for the International Network of Indigenous Health Knowledge and Development conference and a Grant Development Workshop, May 2010

NIDA funding supported the International Network of Indigenous Health Knowledge and Development Conference. A preconference Grant Development Technical Assistance Workshop helped promote a pipeline of investigators, increase technical assistance for the development of AI/AN drug abuse grant applications and foster NIDA accessibility.

NIAMS American Indian Science and Engineering Society (AISES) National Conference November 11-13, 2010

NIAMS Intramural Research Program's Career Development Section and Office of Communications and Public Liaison distributed information about the NIAMS Summer Internship Program. Over 1,400 people—including American Indian and Alaska Native students and professionals, and representatives from corporate, government, academic and Tribal organizations from across the country—attended the conference. Prospective interns were invited to pursue intramural research opportunities by following up with NIAMS staff whom they met at the conference.

National Heart, Lung and Blood Institute (NHLBI) Honoring the Gift of Heart Health Members/Attendees

Rachael Tracy from NHLBI-Division for the Application of Research Discoveries (DARD); IHS Health Promotion, Disease Prevention Program; and IHS Native American Cardiology Program. Meeting Date(s): In FY 2010, members continued to provide feedback on an as needed basis. Where was the meeting held? Teleconference, e-mail, and/or face-to-face meetings at IHS Headquarters in Rockville, MD. Frequency of Meetings: Quarterly and/or on as needed basis. Summary of Yearly Activities, and next steps: The NHLBI, in collaboration with the IHS Health Promotion and Disease Prevention Program, funded a total of 10 pilot projects beginning FY 2007 and continuing through FY 2009. In FY 2010, NHLBI began working with each pilot project to finalize submitted project data for analysis and prepare final reports. Each of the 10 pilot projects planned, implemented, and conducted evaluation activities using a community-based approach. This approach integrated the use of community health workers and community health educators to conduct education and outreach activities to prevent and control CVD risk factors. The primary intervention tool used was the NHLBI's "Honoring the Gift of Heart Health" manual and its associated tools. Ultimately, the NHLBI and the IHS, in partnership with each pilot project, will disseminate their findings through publications, conference presentations, and Web-based literature. These activities support and extend the IHS, Tribal, and Urban Indian Health Program's

existing CVD prevention and control efforts as well as the NHLBI's efforts to address health disparities in minority and underserved populations.

National Center for Complementary and Alternative Medicine (NCCAM) INIHKD Conference 2010 – "Knowing Our Roots Indigenous Medicines, Health Knowledge and Best Practices", Poulsbo, Washington, May 24-28, 2010

During the conference NCCAM and National Institute on Drug Abuse (NIDA) staff held a grantsmanship workshop. The International Network for Indigenous Health Knowledge and Development (INIHKD) assembles indigenous health researchers, scholars, policymakers, and practitioners. These participants are dedicated to improve the health of indigenous peoples in Australia, New Zealand, Canada and the United States through community-led health research, culturally-based health services delivery, indigenous health workforce development, and indigenous health policy advancement.

National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) Special Diabetes Program for Indians (SDPI)

DEM/NIDDK representative serves as Steering Committee member for the SDPI. The DEM representative serves in an advisory capacity to the SDPI competitive grant program supporting demonstration programs among selected Tribal Reservations to implement the Diabetes Prevention Program lifestyle intervention designed for translation in American Indian populations.

AGENCY TRIBAL TECHNICAL ADVISORY GROUP

National Cancer Institute (NCI) Network for Cancer Control Research among American Indian/Alaska Natives Population

NCI supports the Network for Cancer Control Research among American Indian/Alaska Native Populations, a collaborative group of native and non-native researchers and educators in order to exchange information on cancer control research and to improve community links to NCI's researchers, NCI's Cancer Information Service, and the American Cancer Society. Network members recently authored a monograph that provides a comprehensive description of the cancer burden in the AI/AN population in the United States, combining cancer incidence data from CDC's National Program of Cancer Registries and NCI's Surveillance, Epidemiology, and End Results (SEER) Program, along with record linkages and geographic factors. Meetings occur annually in the Spring (March/ April) and Fall. National conferences are held every 3 years.

NIDA Health Research Advisory Council (HRAC) Presentation

A presentation on past activities, current initiatives and future plans was made to the HRAC at the Washington, DC March 18, 2010 meeting.

United States Department of Health and Human Services

Substance Abuse and Mental Health Services (SAMHSA)

The Substance Abuse and Mental Health Services Administration (SAMHSA) has established a clear vision for its work—a life in the community for everyone. To realize this vision, the Agency has sharply focused its mission on building resilience and facilitating recovery for people with or at risk for mental or substance use disorders. Prevention Works … Treatment is Effective… People Recover.

Mission To reduce the impact of substance abuse and mental illness on America's communities. To achieve this mission SAMHSA has 8 Strategic Initiatives that will guide the agency's work. They are:

- Prevention of Substance Abuse and Mental Illness
- Trauma & Justice
- Military Families – Active, Guard, Reserve, and Veteran
- Health Reform
- Recovery Support
- Health Information Technology for Behavioral Health Providers
- Data, Outcomes, and Quality-Demonstrating Results
- Public Awareness and Support

Organization

SAMHSA's core functions are to administer discretionary, formula, and block grant programs; and provide up-to-date information on behavioral health issues and prevention and treatment approaches. This work is achieved through the following Centers:

- Center for Behavioral Health Statistics and Quality (CBHSQ)
- Center for Mental Health Services (CMHS)
- Center for Substance Abuse Prevention (CSAP)
- Center for Substance Abuse Treatment (CSAT)

Contact Information:

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Intradepartmental Council on Native American Affairs Liaison:

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Fax: (249) 276-2010

Website: http://www.samhsa.gov
Tribal Consultation Policy: Yes
Tribal Consultation Workgroup: SAMHSA Tribal Technical Advisory Committee (STTAC)

HIGHLIGHTS OF DIVISION SPECIFIC ACCOMPLISHMENTS/ACTIVITIES

Aberdeen Indian Health Service (IHS) Area Suicide Summit, Bismarck, ND, July 20-22

Dr. Michelle Carnes was in attendance at the Aberdeen Area Suicide Summit to participate in behavioral health strategic planning for this IHS area (where many of the SAMHSA Garrett Lee Smith Suicide Prevention (GLS) tribal grantees are located). Tribal dignitaries and spiritual leaders were invited and attended the Summit which also addressed how culture and spirituality can relate positively in preventing suicide. Several programs funded through the Indian Health Service Methamphetamine and Suicide Prevention Initiative (MSPI) and the GLS grantees provided presentations on their projects.

IHS Methamphetamine and Suicide Prevention Initiative (MSPI) Grantee Meeting, Oklahoma City, Oklahoma, September 1-2, 2010

To strengthen collaboration between the MSPI and SAMHSA's GLS grant programs in addressing suicide, Dr. Michelle Carnes (CMHS) was in attendance to meet grantees and Project Officers. The MSPI promotes the development of evidence-based and practice-based models that represent culturally-appropriate prevention and treatment approaches to meth abuse and suicide prevention from a community-driven context.

National Action Alliance for Suicide Prevention (NAASP)

On September 10, Secretary Sebelius and Secretary Gates (Defense) launched NAASP. This is a public-private partnership to update and advance the National Strategy for Suicide Prevention, engage and educate the public and examine ways to target high-risk populations such as American Indians and Alaska Natives. SAMHSA has contracted with the Suicide Prevention Resource Center to provide administrative support for the committee. The 35-40 committee members are composed of high level executives and public sector leaders, including two American Indians.

Tribal Justice, Safety, and Wellness (TJSW) Conferences

SAMHSA provided support for two TJSW sessions. Session # 10 was held at the Egan Rushmore Plaza Civic Center, Rapid City, South Dakota, on June 16 – 18, 2010. The TJSW sessions provide an opportunity for joint Federal efforts to conduct additional training and technical assistance sessions to help address issues of concern facing AI/AN communities. The audience includes bringing together elected Tribal leaders and key policy decision makers, Tribal administrators, executive directors, finance and grant

administration officers, Tribal planners, grant writers, justice and law enforcement personnel, Tribal program project coordinators and grantee officers.

SAMHSA and the Indian Health Service sign a joint Dear Tribal Leader (DTL) letter

On September 17 a DTL letter was sent to federally recognized tribes and national AI/AN organizations to inform Tribes of the unique services each agency provides for Indian country. Included in the letter was an update on renewed collaboration activities between the two agencies.

Indian Country Meth Initiative (ICMI)

The ICMI tribes met three times during the reporting period: Albuquerque in March, Santa Fe in April and Rapid City in June. The meetings included SAMHSA staff, Tribal project officers, Tribal leaders, and staff from regional Native non-profit partner organizations. The purpose of the meetings was to share promising practices.

DIVISION SPECIFIC ACTIVITIES

Tribal Law and Order Act (TLOA)

The Act was signed into law on July 29, 2010 and mandated new responsibilities for SAMHSA. In August, Mr. Dennis Romero was appointed as acting director for the new Office of Indian Alcohol and Substance Abuse. Mr. Romero immediately implemented a rigorous information campaign and Tribal outreach. He made presentations at national and regional meetings including the National Indian Health Board Consumer's Conference and the Affiliated Tribes of Northwest Indians. In addition, he participated in the Bureau of Indian Affairs/Department of Justice joint Tribal consultation sessions.

To Live to See the Great Day That Dawns: HHS Publication #SMA (10)-4480, CMHS-NSPI-0196

This 169-page guide lays the groundwork for comprehensive prevention planning in support of American Indian and Alaska Native (AI/AN) communities and their efforts to develop effective, culturally appropriate suicide prevention plans. This free publication is available for ordering online via SAMHSA's Web site at www.SAMHSA.gov.

Native American Center for Excellence (NACE)

Following a very successful 3-year SAMHSA contract, providing service to over 100 American Indian and Alaska Native (AI/AN) communities, NACE 2 was awarded in September 2010 and will allow for an additional 5 years of service. NACE is a Prevention Technical Assistance Resource Center, a first-of-its-kind national project to promote effective substance abuse prevention programs in AI/AN communities.

AFFORDABLE CARE ACT ACTIVITIES SPECIFIC TO TRIBES

SAMHSA convened a Healthcare Reform Stakeholders group composed of Federal offices and public sector behavioral health organizations in order to have the opportunity to obtain a wide variety of feedback as SAMHSA works to implement the Affordable Care Act (ACA). The National Congress of American Indians is included in this group and has hosted the monthly meetings on several occasions. In addition, SAMHSA provided a general overview on ACA provisions for the SAMHSA TTAC on June 18, 2010.

TRIBAL DELEGATION MEETINGS

SAMHSA Tribal Consultation, Rapid City, South Dakota, June 18, 2010

SAMHSA hosted a consultation session to obtain feedback from Tribal Leaders on ways to improve SAMHSA's grant award process and on proposed SAMHSA Strategic Initiatives. The session was held during the Tribal Justice, Safety, and Wellness Conference.

Senator Dorgan's Indian Youth Suicide Prevention Summit, **Washington, DC**

On July 23, SAMHSA was invited to attend this convening of Tribal leaders, AI/AN youth, national Native and non-Native organizations, and other federal offices to discuss resources, promising practices, and prevention strategies.

Alaska Native Health Board Visits & Consultation. **August 9-13.**

Administrator Hyde joined other HHS principals and Veterans Administration staff for on-site visits to the Yukon-Kuskokwim Health Corporation, the Bethel Health Corporation, and for a one-day consultation at the Alaska Native Health Board Summit.

TRIBAL ENGAGEMENTS

IHS Behavioral Health Conference on July 27, 2010

Administrator Hyde provided a video message for a plenary session.

National Indian Health Board Annual Consumer's Conference in Rapid City, South Dakota, September 21, 2010

Administrator Hyde provided opening remarks.

SAMHSA Tribal Technical Advisory Committee (SAMHSA TTAC)

SAMHSA established the TTAC in February 2008. The committee is composed of 14 elected/appointed Tribal leaders. The committee is charged with providing information on the public health needs of American Indians and Alaska Natives, especially identifying urgent substance abuse and mental health needs, and discussing collaborative approaches to meeting those needs. Administrator Hyde met with the SAMHSA TTAC on two occasions: February 26 as an inaugural meet and greet with her; and on June 17 in Rapid City, South Dakota, during the Tribal Justice, Safety, and Wellness Conference.

SAMHSA Tribal Consultation Policy (TCP)

SAMHSA has had an agency specific TCP since 2007. Appropriate updates will be made to the SAMHSA TCP upon receipt of the approved revised HHS TCP.

United States Department of Health and Human Services

Intradepartmental Council on Native American Affairs (ICNAA)

The Intradepartmental Council on Native American Affairs (ICNAA), authorized by the Native American Programs Act of 1974 (42USC2991), as amended, serves as the focal point within the Department of Health and Human Services (HHS) for coordination and consultation on health and human services issues affecting the American Indian, Alaska Native and Native American (AI/AN/NA) population, which includes more than 560 federally recognized tribes, approximately 60 tribes that are state recognized or seeking federal recognition, Indian organizations, Native Hawaiian communities, and Native American Pacific Islanders, including Native Samoans.

It brings together HHS leadership to ensure consistency on policy affecting American Indians, Alaska Natives and Native Americans, and to maximize limited resources. The major functions of the ICNAA are to:

- Develop & promote HHS policy that provides greater access;
- Assist in the Tribal Consultation process;
- Develop both short term & long term strategic plans;
- Promote self-sufficiency and self-determination;
- Develop legislative, administrative, and regulatory proposals to benefit Native Americans; and
- Promote the Government-to-Government relationship as reaffirmed by the President

Membership

The ICNAA membership consists of each of the HHS Operating Divisions heads, Staff Division heads, the Director, Office of Intergovernmental Affairs, the Director, Center for Faith-Based and Community Initiatives, the Executive Secretary to the Department, and two HHS regional representatives.

Direction and Oversight

The ICNAA is located in the Office of Intergovernmental Affairs (IGA), Immediate Office of the Secretary and provides executive direction and coordination with the Council Chairperson on all Council activities.

The Commissioner, Administration for Native Americans (ANA), is the Chairperson and the Director, Indian Health Service (IHS) is the Vice-Chairperson. The Chairperson is charged with the overall direction of the Council and shall preside over all Council activities, including Council meetings and Executive Committee meetings.

The Executive Committee, comprised of the Chairperson and Vice-Chairperson, the Assistant Secretaries for Children and Families, Aging, Health, and Resource and Technology and the IGA Director, is authorized to act on behalf of the Council, and is responsible for overseeing Council functions and recommending subjects and actions for consideration by the full Council.

Management and Administration

IGA's Principal Advisor on Tribal Affairs serves as the principal management officer for all Council functions, including management and administration of Council activities, the administration of funds provided for Council activities, and in consultation with the Executive Committee, preparation of agendas for Council meetings, and maintaining records of Council business, including minutes from Council meetings. The Principal Advisor is the primary liaison between Council members, and other Federal agencies, and reports directly to the Council Chairperson and Vice-Chairperson. The Council meets no less than twice a year. At least one Council tribal liaison has been appointed by each ICNAA member to work with IGA on special projects, and on the implementation of Secretarial initiatives and policies affecting AI/AN/NAs.

A key element of the Office of Intergovernmental Affairs (IGA) mission is to facilitate communication regarding health and human services (HHS) initiatives as they relate to state, local, and tribal governments. The Office of Tribal Affairs within IGA coordinates and manages IGA's tribal and native policy issues, assists tribes in navigating through HHS programs and services, and coordinates the Secretary's policy development for tribes and national native organizations. The ten Regional Offices housed in IGA are one of the key components in the ongoing relationship building HHS has with all the federally recognized tribes in the United States.

The ten Regional Offices (ORD) are the lead organizers of the annual regional tribal consultations. In this responsibility the ORD in conjunction with the tribal leaders in their respective region plan, coordinate, and conduct consultation meetings. At these meetings the tribal leaders meet with HHS Regional Operating Division staff as well as HHS headquarters leadership to discuss policy changes that impact their respective tribal community. This true government-to-government conversation reaffirms and promotes the sustaining relationships the ORD has with the tribal leaders.

Throughout the year, the ORD continues these exchanges and addresses all the ICNAA priorities. ORD bi-monthly report document this activity, but the constant and consistent interaction the ORD has with the tribal leaders cannot be overlooked. The priorities of Emergency Preparedness, Health Promotion and Disease Prevention, and Increased Access to HHS Programs and Grants are areas that the ORD is able to positively impact. From the wildfires in California, the flooding in the Plains, to the distribution of

educational materials, and the face –to-face technical assistance from regional Operating Division personnel to tribal leaders and their councils are just a few examples of cooperative work between HHS and tribal nations. These interactions are often times held on a weekly basis. The meetings, phone calls, and emails, though too numerous to list; represent the groundwork of the relationship that the ORD has with the tribes. The ORD and the work of ICNAA go hand in hand. The tribal consultations and the daily connections with tribal leaders allow the ORD to deepen the connections with Indian Country.

Status and Activities

- Tribal consultation activities across HHS, is an ICNAA priority and is required by Presidential Order 13175. The annual two day HHS Tribal Budget Consultation sessions as well as the regional HHS Tribal consultations have proven to be very successful in assuring that AI/AN communities have an opportunity to communicate their health and human services needs and priorities to high level HHS officials. These consultations are partly responsible for a significant increase in the HHS resources that have gone to the AI/AN/NAs community (an increase of over $394 million between FY 2008 and FY 2009).
- ICNAA assists the HHS Office of Minority Health in providing guidance by suggesting research issues that need attention (training opportunities for young Native researchers, developing appropriate protocols to ensure AI/AN cohorts are considered for national sponsored research studies, etc.) to the newly formed HHS AI/AN Health Research Advisory Council.

Although, the Indian Health Service serves as the main conduit for the provision of federally supported health care for federally recognized tribal nations, this responsibility is shared with all HHS agencies because of the overarching government to government relationship between the federal government and the 562 tribal nations. ICNAA serves to support this relationship across all of HHS which fosters a more meaningful provision of health and human services for AI/AN/NA communities. Accomplishments are expected to continue in order that more HHS resources are made available to AI/AN/NAs communities by analyzing and instituting the next level of recommendations of the Barriers Study; to continue to support HHS-wide tribal consultation; support new initiatives such as tribal emergency preparedness and the newly established HHS American Indian and Alaska Native Health Research Advisory Council and to continue to serve as the HHS focal point for Native American health and human services.

The 2010 priorities of the Council for are:

1. Increase Access to HHS Programs and Grants: Improve Technical Assistance for all AI/AN/NA's
2. Increase Awareness and Effectiveness of Human Services with Native Populations
3. Tribal Consultation

Plans for 2011

The Council met in October 2010 with Secretary Sebelius to begin addressing the Council activities and plans for this upcoming year and forward. Secretary Sebelius and the ICNAA Leadership charged HHS to identify potential changes that could improve HHS policies and programs and increase our Tribal collaborations and outreach. Each ICNAA member was been asked to examine its funding opportunities through States and grants to determine strategies for more directly targeting tribal populations. At a subsequent ICNAA meeting, a grants subgroup was established. The subgroup met to identify next steps and develop a strategy. At the Subgroup meeting four areas were identified that the group would focus on for this year. The areas include:

1. Access and Availability
2. Outreach & Technical Assistance
3. Grants Eligibility Review
4. Expansion of Services and Pilot Development(Self-governance Expansion, Tribal/State Relations)

United States Department of Health and Human Services

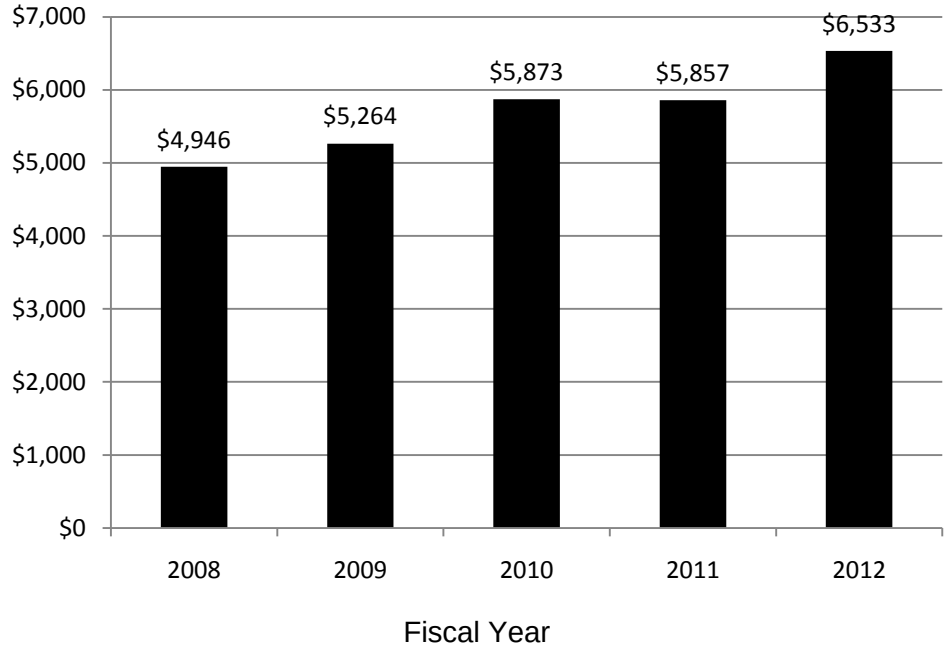
APPENDICES

APPENDIX I

HHS TRIBAL BUDGET

HHS Tribal Resource Trends
FY 2008 – 2012

(Dollars in millions)



FY 2010-2012 HHS FUNDING
FOR AMERICAN INDIANS AND ALASKA NATIVES
(dollars in millions)

Program	FY 2010	FY 2011 Continuing Resolution	FY 2012 President's Budget
Indian Health Service: 1/	**$5,100.4**	**$5,116.4**	**$5,689.0**
Administration For Children and Families (ACF):			
Head Start 2/	$242.1	$207.5	$237.6
Administration for Native Americans	$48.8	$48.8	$48.8
Low Income Home Energy Assistance	$55.4	$49.8	$22.1
Child Care and Development Block Grant	$42.5	$42.5	$58.5
Child Care Entitlement	$58.3	$58.3	$63.1
Family Violence	$13.0	$13.0	$13.5
Community Services Block Grant	$4.9	$4.9	$2.5
Community-Based Child Abuse Prevention	$1.6	$0.4	$0.4
Promoting Safe and Stable Families	$11.0	$11.0	$11.0
Tribal TANF	$180.1	$181.0	$181.0
Healthy Marriage and Responsible Fatherhood	$1.5	$1.5	$1.5
Tribal Work Program	$7.6	$7.6	$7.6
Tribal Child Support	$36.0	$42.0	$42.0
Tribal Foster Care	$3.0	$8.0	$39.0
Child Welfare Services (IV-B)	$6.1	$6.1	$6.1
Developmental Disabilities	$0.2	$0.2	$0.2
Subtotal, ACF	**$712.3**	**$682.8**	**$735.1**
Health Resources and Services Administration:			
Health Careers Opportunity Program	$0.9	$0.9	$0.9
Patient Navigator and Chronic Disease Prevention	$0.5	$0.5	--
Centers of Execellence	$1.2	$1.2	$1.2
Subtotal, HRSA	**$2.6**	**$2.6**	**$2.1**
Administration on Aging:			
Native American Elder Rights	--	--	$1.5
Native American Nutrition and Supportive Services	$27.7	$27.7	$27.7
Native American Caregiver Support Services	$6.4	$6.4	$8.4
Nutrition Services Incentive Program	$2.1	$2.1	$2.1
Program Innovations	$0.8	$0.8	$0.8
Subtotal, AoA	**$37.0**	**$37.0**	**$40.5**

FY 2010-2012 HHS FUNDING
FOR AMERICAN INDIANS AND ALASKA NATIVES
(dollars in millions)

Program	FY 2010	FY 2011 Continuing Resolution	FY 2012 President's Budget
Centers For Disease Control and Prevention:			
Preventive Health and Health Services Block Grant.....	$0.1	$0.1	--
Local STD screening and treatment.....	$1.5	$1.5	$1.5
Subtotal, CDC.....	**$1.6**	**$1.6**	**$1.5**
Substance Abuse & Mental Health Services Administration (SAMHSA):			
Behavioral Health Tribal Prevention Block Grant.....	--	--	$50.0
Circles of Care.....	$3.0	$2.9	$2.5
Mental Health/Suicide Prevention.....	$2.9	$2.9	$2.9
Children's Mental Health Services Program.....	$11.8	$8.9	$8.2
Protection and Advocacy.....	$0.2	$0.2	$0.2
Substance Abuse Block Grant.....	$0.6	$0.6	$0.5
Subtotal, SAMHSA…….	**$18.6**	**$15.7**	**$64.3**
HHSTOTAL.....	**$5,873**	**$5,856**	**$6,533**

1/ Includes insurance collections, rental of staff quarters and mandatory diabetes funding.
2/ Funding for these activities are authorized under Section 640(a)(3)(A)(i)(II) of the "Improving Head Start for School Readiness Act of 2007."

APPENDIX II

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES TRIBAL CONSULTATION POLICY

U. S DEPARTMENT OF HEALTH AND HUMAN SERVICES

TRIBAL CONSULTATION POLICY

1. PURPOSE

The U. S. Department of Health and Human Services (HHS) and Indian Tribes share the goal to establish clear policies to further the government-to-government relationship between the Federal Government and Indian Tribes. True and effective consultation shall result in information exchange, mutual understanding, and informed decision-making on behalf of the Tribal governments involved and the Federal Government. The importance of consultation with Indian Tribes was affirmed through Presidential Memoranda in 1994, 2004 and 2009, and an Executive Order (EO) in 2000.

The goal of this policy includes, but is not limited to, eliminating health and human service disparities of Indians, ensuring that access to critical health and human services is maximized, and to advance or enhance the social, physical, and economic status of Indians. To achieve this goal, and to the extent practicable and permitted by law, it is essential that Federally-recognized Indian Tribes and the HHS engage in open, continuous, and meaningful consultation.

This policy applies to all Divisions of the Department and shall serve as a guide for Tribes to participate in all Department and Division policy development to the greatest extent practicable and permitted by law.

2. BACKGROUND

Since the formation of the Union, the United States (U.S.) has recognized Indian Tribes as sovereign nations. A unique government-to-government relationship exists between Indian Tribes and the Federal Government. This relationship is grounded in the U.S. Constitution, numerous treaties, statutes, Federal case law, regulations and executive orders that establish and define a trust relationship with Indian Tribes. This relationship is derived from the political and legal relationship that Indian Tribes have with the Federal Government and is not based upon race.

An integral element of this government-to-government relationship is that consultation occurs with Indian Tribes. The Executive Memorandum titled “Tribal Consultation” reaffirmed this government-to-government relationship with Indian Tribes on November 5, 2009. The implementation of this policy is in recognition of this special relationship.

This special relationship is affirmed in statutes and various Presidential Executive Orders including, but not limited to:

- Older Americans Act, P.L. 89-73, as amended;
- Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended;
- Native American Programs Act, P.L. 93-644, as amended;
- Indian Health Care Improvement Act, P.L. 94-437, as amended;
- Personal Responsibility and Work Opportunity Reconciliation Act of 1996, P.L.104-193;
- Presidential Executive Memorandum to the Heads of Executive Departments dated April 29, 1994;
- Presidential Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, November 6, 2000; and
- Presidential Memorandum, Government-to-Government Relationship with Tribal Governments, September 23, 2004
- Presidential Memorandum, Tribal Consultation, November 5, 2009
- American Recovery and Reinvestment Act of 2009, P.L. 111-5, 123 Stat. 115 (Feb. 17, 2009).
- Children's Health Insurance Program Reauthorization Act of 2009, P.L. 111-3, 123 Stat. 8 (Feb. 4, 2009).
- Patient Protection and Affordable Care Act of 2010, P.L. 111-148, 124 Stat. 119 (Mar. 23, 2010).

3. TRIBAL SOVEREIGNTY

This policy does not waive any Tribal Governmental rights and authority, including treaty rights, sovereign immunities or jurisdiction. Additionally, this policy does not diminish any rights or protections afforded other American Indians or Alaskan Natives (AI/AN) or entities under Federal law.

The special government-to-government relationship between the Federal Government and Indian Tribes, established in 1787, is based on the Constitution, and has been given form and substance by numerous treaties, laws, Supreme Court decisions, and Executive Orders, and reaffirms the right of Indian Tribes to self-government and self-determination. Indian Tribes exercise inherent sovereign powers over their citizens and territory. The U.S. shall continue to work with Indian Tribes on a government-to-government basis to address issues concerning Tribal self-government, Tribal trust resources, Tribal treaties and other rights.

Tribal self-government has been demonstrated to improve and perpetuate the government-to-government relationship and strengthen Tribal control over Federal funding that it receives, and its internal program management. Indian Tribes participation in the development of public health and human services policy ensures locally relevant and culturally appropriate approaches to public issues.

4. POLICY

Before any action is taken that will significantly affect Indian Tribes it is the HHS policy that, to the extent practicable and permitted by law, consultation with Indian Tribes will occur. Such actions refer to policies that:

1. Have Tribal implications, and
2. Have substantial direct effects on one or more Indian Tribes, or
3. On the relationship between the Federal Government and Indian Tribes, or
4. On the distribution of power and responsibilities between the Federal Government and Indian Tribes.

Nothing in this policy waives the Government's deliberative process privilege. Examples of the government's deliberative process privilege are as follows:

1. The Department is specifically requested by Members of Congress to respond to or report on proposed legislation, the development of such responses and of related policy is a part of the Executive Branch's deliberative process privilege and should remain confidential.
2. In specified instances Congress requires the Department to work with Indian Tribes on the development of recommendations that may require legislation, such reports, recommendations or other products are developed independent of a Department position, the development of which is governed by Office of Management and Budget (OMB) Circular A-19.

A. Each HHS Operating and Staff Division (Division) shall have an accountable process as defined in Sections 8 and 9 of this policy to ensure meaningful and

timely input by Indian Tribes in the development of policies that have Tribal implications. If Divisions require technical assistance in implementing these sections, the Office of Intergovernmental Affairs (IGA) can provide and/or coordinate assistance.

B. To the extent practicable and permitted by law, no Division shall promulgate any regulation that has Tribal implications, or that imposes substantial direct compliance costs on Indian Tribes, or that is not required by statute, unless:

1. Funds necessary to pay the direct costs incurred by the Indian Tribe in complying with the regulation are provided by the Federal Government; or
2. The Division, prior to the formal promulgation of the regulation,
    a. Consulted with Indian Tribes throughout all stages of the process of developing the proposed regulation;
    b. Provided a Tribal summary impact statement in a separately identified portion of the preamble to the regulation as it is to be issued in the Federal Register (FR), which consists of a description of the extent of the Division's prior consultation with Indian Tribes, a summary of the nature of their concerns and the Division's position supporting the need to issue the regulation, and a statement of the extent to which the concerns of Tribal officials have been met; and
    c. Made available to the Secretary and to the Director of OMB any written communications submitted to the Division by Tribal officials.

C. To the extent practicable and permitted by law, no Division shall promulgate any regulation that has Tribal implications and that preempts Tribal law unless the Division, prior to the formal promulgation of the regulation,

1. Consulted with Tribal officials throughout all stages of the process of developing the proposed regulation;
2. Provided a Tribal summary impact statement in a separately identified portion of the preamble to the regulation as it is to be issued in the FR, which consists of a description of the extent of the Division's prior consultation with Tribal officials, a summary of the nature of their concerns and the Division's position supporting the need to issue the regulation, and a statement of the extent to which the concerns of Tribal officials have been met; and
3. Made available to the Secretary any written communications submitted to the Division by Tribal officials.

D. On issues relating to Tribal self-governance, Tribal self-determination, Tribal trust resources, or Tribal treaty and other rights, each Division shall make all practicable attempts where appropriate to use consensual mechanisms for developing regulations, including negotiated rulemaking.

5. PHILOSOPHY

Indian Tribes have an inalienable and inherent right to self-government. Self-government

means government in which decisions are made by the people who are most directly affected by the decisions. As sovereign nations, Indian Tribes exercise inherent sovereign powers over their members, territory and lands.

HHS has a long-standing commitment to working on a government-to-government basis with Indian Tribes and to work in partnership with AI/ANs. Also, HHS is committed to enhancing the collaboration among its Divisions to address Tribal issues and promoting the principle that each Division bears responsibility for addressing Tribal issues within the context of their mission.

IGA is identified as the responsible HHS entity, located in the Immediate Office of the Secretary (IOS) for monitoring compliance with EO 13175 and the Department Tribal Consultation Policy. In addition, the Secretary has charged the Intradepartmental Council on Native American Affairs (ICNAA) to meet regularly and no less then 2 times a year and to provide advice on all HHS policies that relate to Indian Tribes as well as instances where HHS activities relate to Native Americans. Regional consultation sessions have been developed as a systematic method to regularly consult with Indian Tribes on HHS programs at field locations. The goal of these efforts is to focus HHS on Tribal issues, to continue to enhance the government-to-government relationship between Indian Tribes and the U.S., as well as to make resources of HHS more readily available to Indian Tribes.

6. OBJECTIVES

1. To formalize the Administration's policy that HHS seek consultation and the participation of Indian Tribes in the development of policies and program activities that impact Indian Tribes.
2. To establish a minimum set of requirements and expectations with respect to consultation and participation throughout HHS management, the Office of the Secretary (OS) Division, and Regional levels.
3. The need to consult may be identified by the Department or by an Indian Tribe(s). Any time the Tribe(s) or the Department identifies a critical event the Department may initiate any necessary consultation in accordance with this policy.
4. To identify events and partnerships that HHS would participate with Indian Tribe(s) and Tribal/Indian Organizations that establish and foster partnerships with HHS which complement and enhance consultation with Indian Tribes.
5. To promote and develop innovative consultation methods with Indian Tribes in the development of HHS policy and regulatory processes.
6. To uphold the responsibility of HHS to consult with Indian Tribes on new and existing health and human service policies, programs, functions, services and activities that have Tribal implications.
7. To charge and hold accountable each of the HHS Operating Division Heads for the implementation of this policy.
8. To be responsive to requests by an Indian Tribe(s) request for consultation and technical assistance in obtaining HHS resources.
9. To charge the HHS Operating Divisions with the responsibility for enhancing partnerships with Indian Tribes which will include, requests for technical assistance, access to programs and resources, as well as collaborating with Tribal subject matter expertise.
10. To provide a single point of contact within HHS and its Operating Divisions for Indian Tribes at the highest level which would have access to the IOS, the Deputy

Secretary, and Operating Division Heads. The Principal Advisor for Tribal Affairs and the Division Tribal points of contact will be responsible for compliance with this policy and ensuring timeframes identified in section 9 are met.

7. CONSULTATION PARTICIPANTS AND ROLES

1. **Indian Tribes:** The government-to-government relationship between the U.S. and Federally recognized Indian Tribes dictates that the principal focus for HHS consultation is Indian Tribes, individually or collectively.
2. **Indian Organizations:** At times it is useful that the HHS communicate with Indian organizations to solicit Indian Tribe(s) advice and recommendations. The government does not participate in government-to-government consultations with these entities; rather these organizations represent the interest of Indian Tribes when authorized by those Tribes These organizations by the sheer nature of their business serve and advocate Indian Tribes issues and concerns that might be negatively affected if these organizations were excluded from the process.
3. **Office of Intergovernmental Affairs (IGA):** IGA is responsible for Department-wide implementation and monitoring of EO 13175 for HHS Tribal consultation. IGA serves as the Department's point of contact in accessing department-wide information. The single point of contact within the IGA for Indian Tribes and other Tribal/Indian organizations, at a level with access to all HHS Divisions, is the Principal Advisor for Tribal Affairs. As a part of the IOS, IGA's mission is to facilitate communication regarding HHS initiatives as they relate to Tribal, State, and local governments. IGA is the Departmental liaison to States and Indian Tribes, and serves the dual role of representing the States and Tribal perspective in the Federal policymaking process, as well as, clarifying the Federal perspective to States and Indian Tribes, including Tribal consultation.
4. **Assistant Secretary for Finance and Resources (ASFR):** ASFR is the lead office for budget consultation for the overall departmental budget request.
5. **HHS Divisions:** The Department has numerous Staff Divisions and Operating Divisions under its purview. Each of the these Divisions share in the Department-wide responsibility to coordinate, communicate and consult with Indian Tribes on issues that affect these governments. All Operating Divisions shall establish a Tribal consultation policy to comply with the HHS Policy. All Divisions are responsible for conducting Tribal consultation to the extent practicable and permitted by law on policies that have Tribal implications.
6. **Intradepartmental Council on Native American Affairs(ICNAA):** The ICNAA is charged with: (1) develop and promote an HHS policy to provide greater access and quality services for AI/AN/NAs throughout the Department; (2) promote implementation of HHS policy and Division plans on consultation with Indian Tribes in accordance with statutes and EOs; (3) promote an effective, meaningful AI/AN/NA policy to improve health and human services for AI/AN/NAs; (4) develop a comprehensive Departmental strategy that promotes self-sufficiency and self-determination for all Indian Tribes and AI/AN/NA people; (5) promote the Tribal/Federal Government-to-government relationship on an HHS-wide basis in accordance with EO 13175; and (6) operate in accordance with policy and timeframes identified within ICNAA charter and as directed by the Secretary and the ICNAA Executive Leadership.
7. **Regional Offices:** The ten (10) HHS Regional Offices share in the Department-wide responsibility to consult, coordinate and communicate with Indian Tribes on

issues that affect Indian Tribes and HHS programs, services and resources available to Indian Tribes through States. The Regional Directors are the Secretary's immediate representatives in the field for the HHS. Each of the Regional Office(s) shall conduct an annual regional Tribal consultation meeting with Indian Tribes in their respective regions. Additional meetings may be conducted if requested by the Regional Director or an Indian Tribe(s) within the Region. Further, the Regional Directors will work closely with the respective Indian Tribes and State Governments to assure continuous coordination and communication between Tribes and States. The Regional Office Directors will promote and comply with this policy and its timeframes identified in Section 9.

8. TRIBAL CONSULTATION PROCESS

An effective consultation between HHS and Indian Tribes requires trust between all parties which is an indispensable element in establishing a good consultative relationship. The degree and extent of consultation will depend on the identified critical event. A critical event may be identified by HHS and/or an Indian Tribe(s). Upon identification of an event significantly affecting one or more Indian Tribe(s), HHS will initiate consultation regarding the event. In order to initiate and conduct consultation, the following serves as a guideline to be utilized by HHS and Indian Tribes:

1. Identify the Critical Event: Complexity, implications, time constraints, and issue(s) (including policy, funding/budget development, programs, services, functions and activities).
2. Identify affected/potentially affected Indian Tribe(s)
3. Determine Consultation Mechanism – The most useful and appropriate consultation mechanisms can be determined by HHS and/or Indian Tribe(s) after considering the critical event and Indian Tribe(s) affected/potentially affected. Consultation mechanisms include but are not limited to one or more of the following:
    a. Mailings
    b. Teleconference
    c. Face-to-Face Meetings at the Local, Regional and National levels between the HHS and Indian Tribes.
    d. Roundtables
    e. Annual HHS Tribal Budget and Policy Consultation Sessions.
    f. Other regular or special HHS Division or program level consultation sessions.

A. Communication Methods: The determination of the critical event and the level of consultation mechanism to be used shall be communicated to affected/potentially affected Indian Tribe(s) using all appropriate methods and with as much advance notice as practicable. These methods include but are not limited to the following:

1. **Correspondence:** Written communications shall be issued within 30 calendar days of an identified critical event. The communication should clearly provide affected/potentially affected Indian Tribe(s) with detail of the critical event, the manner and timeframe in which to provide comment. The HHS frequently uses a "Dear Tribal Leader Letter" (DTLL) format to notify individual Indian Tribes of consultation activities. Divisions should work closely with the

Principal Advisor for Tribal Affairs, IOS/IGA if technical assistance is required for proper format and protocols, current mailing lists, and content.

2. **Official Notification:** Within 30 calendar days, and upon the determination the consultation mechanism, proper notice of the critical event and the consultation mechanism utilized shall be communicated to affected/potentially affected Indian Tribe(s) using all appropriate methods including mailing, broadcast e-mail, FR, and other outlets. The FR is the most formal HHS form of notice used for consultation.

3. **Meeting(s):** The Division shall convene a meeting, within 60 calendar days of official notification, with affected/potentially affected Indian Tribe(s) to discuss all pertinent issues in a national, regional, and/or local forum, or as appropriate, to the extent practicable and permitted by law, when the critical event is determined to have substantial impact.

4. **Receipt of Tribal Comment(s):** The Division shall develop and use all appropriate methods to communicate clear and explicit instructions on the means and time frames for Indian Tribe(s) to submit comments on the critical event, whether in person, by teleconference, and/or in writing and shall solicit the advice and assistance of the Principal Advisor for Tribal Affairs, IOS/IGA.

5. **Reporting of Outcome:** The Division shall report on the outcomes of the consultation within 90 calendar days of final consultation. For ongoing issues identified during the consultation, the Division shall provide status reports throughout the year to IOS/IGA and Indian Tribe(s).

A. HHS Response to Official Tribal Correspondence: Official correspondence from an Indian Tribe may come in various forms, but a resolution is the most formal declaration of an Indian Tribe's position for the purpose of Tribal consultation. In some instances, Indian Tribes will submit official correspondence from the highest elected and/or appointed official(s) of the Tribe. HHS will give equal consideration to these types of correspondence. Once HHS receives an official Indian Tribe correspondence and/or resolution, the Secretary/Deputy Secretary and/or their designee should respond appropriately. The process for official correspondence to Indian Tribes is described below:

1. Correspondence submitted by Indian Tribes to HHS shall be officially entered into HHS correspondence control tracking system and referred to the appropriate Division(s).
2. Acknowledgement of Correspondence: HHS and/or Divisions shall provide acknowledgement to Indian Tribes within 15 working days of receipt.
3. Official Response to an identified critical event: HHS shall provide an official response to Indian Tribes that includes: the Division head responsible for follow up, the process for resolution of the critical event and timeline for resolution.
    a. If an identified critical event is national in scope the Department shall to the extent practicable respond to the request within 60 working days or less.

b. If a critical event is specific to a single Indian Tribe the Department shall to the extent practicable respond to the request within 45 working days or less.

B. Policy Development through Tribal Consultation Process: The need to consult on the development or revision of a policy may be identified from within HHS, an HHS Division or may be identified by Indian Tribes. This need may result from external forces such as Executive, Judicial, or Legislative Branch actions or otherwise. Once the need to consult on development or revision of a policy is identified the consultation process must begin in accordance with critical events and consultation mechanisms described above. HHS Divisions may request technical assistance from IGA for the Tribal consultation process.

C. Schedule for Consultation: Divisions must establish and adhere to a formal schedule of meetings to consult with Indian Tribes and their representatives concerning the planning, conduct, and administration of applicable activities. Divisions must involve Tribal representatives in meetings at every practicable opportunity. Divisions are encouraged to establish additional forums for Tribal consultation and participation, and for information sharing with Tribal leadership. Consultation schedules should be coordinated with IGA to avoid duplications or conflicts with other national Tribal events. HHS Divisions should make every effort to schedule their consultations in conjunction with the Annual Regional Tribal Consultation Sessions.

9. CONSULTATION PROCEDURES AND RESPONSIBLITIES

The HHS Tribal consultative process shall consist of direct communications with Indian Tribes, and Indian organizations as applicable, in various ways:

A. **Consultation Parties and Mechanisms- Consultation Occurs:**

1. When the HHS Secretary/Deputy Secretary, or their designee, meets and/or exchanges written correspondence with a Tribal President/Chair/Governor/Chief/Principal Chief and/or elected/appointed Indian Tribal Leader, or their designee to discuss issues concerning either party.
2. When an HHS Division Head, or their designee, meets or exchanges written correspondence with an Indian Tribal representative designated by an elected/appointed Tribal leader to discuss issues or concerns of either party.
3. When an HHS Regional Director, who is the Secretary's representative in the field, meets or exchanges written correspondence with an elected/appointed Indian Tribal Leader, or their designee to discuss issues or concerns of either party.
4. When the Secretary/Deputy Secretary/HHS Division Head, or their designee, meets or exchanges written correspondence with a Tribal representative designated by an elected/appointed Indian Tribal leader to discuss issues or concern of either party.

B. Consultation Procedures

1. **Tribal:** Specific consultation mechanisms that will be used to consult with an Indian Tribe(s) include but are not limited to mailings, meetings, teleconference and roundtables.
   a. An Indian Tribe(s) has the ability to initiate consultation, i.e. meet one-on-one with an HHS Division Head or designated representative to consult on issues specific to that Indian Tribe.
   b. HHS Division Heads will initiate consultation to solicit official Indian Tribe(s)' comments and recommendations on policy and budget matters affecting Indian Tribe(s). These sessions at roundtables, forums and meetings will provide the opportunity for meaningful dialogue and effective participation by Indian Tribe(s).
   c. National/Regional Inter-Tribal Forums: Other types of meetings and/or conferences occur which may not be considered consultation sessions, but these meetings may provide opportunities to share information, conduct workshops, and provide technical assistance to Indian Tribes.
2. **HHS:** Consultation mechanisms that will be used to consult with Indian Tribe(s) include but are not limited to mailings, meetings, teleconferences and roundtables. HHS has various organizational avenues in which Tribal issues and concerns are addressed. These avenues include the OS, the ICNAA, Regional Offices, and Divisions.

   1. **Office of the Secretary**
      a. The HHS National Tribal Consultation Sessions are designed to solicit Indian Tribes' health and human services priorities and program needs. The Sessions provide an opportunity for Indian Tribes to articulate their recommendations on budgets, regulations, policies and legislation.
         i. Upon completion of consultation, HHS will document and notify Indian Tribes on the proceedings, noting positions and following-up on all issues raised that would benefit from ongoing consultation with Indian Tribe(s) within 90 calendar days.
   2. **ICNAA**
      a. The ICNAA represents the internal HHS team providing consistent direction across the Divisions for AI/AN/NA issues. One of the primary responsibilities of ICNAA is to solicit Tribal input in establishing Tribal policy and budget priorities and recommendations for Divisions.

         The health and human service priorities established by Indian Tribes are used to inform the development of the Divisions' annual performance goals and measures for improving health and human services, which are linked to their budget requests.
   3. **Regional Offices**
      a. Regional Offices will work with the Indian Tribes and Indian organizations within their respective regional area in facilitating the Tribal perspective with HHS programs, services, functions, activities and planning Tribal regional consultation sessions. HHS Divisions have various geographic coverage, however all HHS

Divisions, regardless of geographic location, are intended to serve Indian Tribe(s) in their respective locations.

b. Regional Offices/Directors will work collaboratively with the HHS Division lead regional representative in communicating and coordinating on issues and concerns of Indian Tribes in those respective regions or areas.
c. Regional Offices/Directors will work collaboratively to facilitate Tribal-State relations as they affect Indian Tribes in the delivery of HHS programs and services.
d. Regional Tribal Consultation Sessions are held to solicit Indian Tribe(s)' priorities and needs on health and human services. The sessions also provide Indian Tribes with a regional perspective and shall be held, at least but not limited to, annually with status reports to Indian Tribe(s) as appropriate throughout the year, or at least biannually.

    1. Regional Consultations will occur between February and April of every year.
    2. Regional Consultations shall be utilized as a venue for Divisions to coordinate their consultation responsibilities in a manner that is feasible and convenient for Indian Tribes.
    3. Regional Offices/Directors will contact Indian Tribes and Indian Organizations in their respective regions to assist in the planning of the session. This will ensure inclusion of all perspectives and issues for the session.
    4. Protocol will ensure that the highest ranking official present from each respective Indian Tribe is given the opportunity to address the session first, followed by other elected officials, those designated by official letter to represent their respective Indian Tribe and representatives of Indian Organizations.
        a. Official letter from the Indian Tribe designating a representative must be presented to Regional Director before the session begins.
    5. Regional Offices/Directors will seek the assistance of Tribal Leaders to assist with moderating the annual regional consultation session.
    6. The official record of every regional session will be left open for 30 calendar days after the conclusion of the session for submission of additional comments/materials from Indian Tribe(s)
    7. Regional Offices/Directors will provide a summary no later than 45 calendar days after the consultation of the session.

4. **HHS Divisions**
    a. Divisions will work collaboratively with the Indian Tribes on the development of consultation meetings, one-on-one meetings, roundtables, teleconferences and annual sessions.
    b. Divisions will work collaboratively with Indian Tribes on developing and implementing their respective Tribal Consultation Policy or Plan.

c. Divisions will coordinate with IGA on their respective consultation activities in order to ensure that HHS and its Divisions are conducting Tribal consultation coordinating in a manner that is feasible and conducive to the needs of Indian Tribes.
d. Divisions will participate in both the Annual Tribal Budget and Policy Consultation Session and Annual Regional Tribal Consultations with Indian Tribes.
e. Divisions will work collaboratively to facilitate Tribal-State relations as they affect Indian Tribes and AI/ANs in the delivery of HHS programs and services.

3. **States:** In some instances the authority and program funding for HHS programs is administered by the States on behalf of Indian Tribes. The Divisions will consult with the Office of the General Counsel to determine whether these arrangements are based on statutes, regulations, or policy decisions. If there is no clear regulatory or statutory basis mandating that States administer the program on behalf of the Tribe(s), the Division will consult with the affected Indian Tribe(s) as soon as practicable to review alternate options.

   If there is a statutory basis mandating that the State administer the program and associated funding on behalf of the Indian Tribe(s) the Division will examine the permissibility of encouraging or mandating a term requiring tribal consultation as a condition of the State's receipt of program funds. If such a term may be mandated regarding State administered programs affecting Indian Tribes it should be incorporated. If it is not permissible, the Division shall facilitate consultation between the State and affected Tribe(s).

   In addition, whenever practicable and permitted by law, the Division shall notify Indian Tribes of funds administered by the State that the Division believes should be allocated to Indian Tribes.

   The Division shall also encourage the State to recognize that Indian Tribal members are entitled to benefits provided to all State citizens and should be provided the same access to State administered or funded services since Tribal members are citizens of the State(s). To the extent possible, data shall be collected and reported about the number of Tribal members served by the State with federal resources.

10. ESTABLISHMENT OF JOINT TRIBAL/FEDERAL WORKGROUPS AND/OR TASKFORCES CONSULTATION PROCEDURES AND RESPONSIBLITIES

The need to develop or revise a policy may be identified from within the Division or by an Indian Tribe(s). When new or revised national policy, regulations or legislation affects an Indian Tribe(s), an Indian Tribe(s) or HHS may recommend the establishment of a workgroup and/or task force. In response, HHS may establish such a workgroup and/or task force to develop recommendations on various technical, legal, regulatory, or policy issues. In such cases, see ADDENDUM 1 which outlines the process for establishing such aforementioned workgroups and/or task forces.

11. **HHS BUDGET FORMULATION**

HHS shall consult with Indian Tribes throughout the development of the HHS Budget formulation process to the greatest extent practicable and permitted by law. The Secretary shall require the Divisions to include a process in their Tribal Consultation Policy/Plan that assures Tribal priorities and needs and requests are identified and considered in the formulation of the HHS budget.

A. HHS Annual Tribal Budget and Policy Consultation Session (ATBPCS): A Department-wide Tribal budget and policy consultation session will be conducted annually to give Indian Tribes the opportunity to present their budget and policy priorities and recommendations to the Department as HHS prepares to receive the budget requests of its Divisions. The session is convened in March of each year as a means for final input in the development of the Department's budget submission to OMB.

1. At a minimum, HHS conducts annually one ATBPCS to ensure the active participation of Indian Tribes in the formulation of the HHS performance budget request as it pertains to Indian Tribes, which will be held at the HHS Headquarters in Washington, DC no later than March each year.
2. HHS will notify Tribes of the date of the consultation no later than 90 days prior to the session.
3. The session will not exceed two days.
4. Each Operating Division Head/Deputy and budget officer will attend their agency's appropriate session(s).
5. Each Operating Division Head/Deputy will participate in other portions of the ATBPCS that affect their respective division.
6. IGA/ASFR will provide a summary of the session to Indian Tribes no later than 30 calendar days after the session has concluded.
7. Within 90 calendar days IGA shall post the transcript of the ATBPCS with a summary of the Indian Tribes' issues/concerns presented at the session.
8. HHS will seek the assistance of Indian Tribal Leaders to assist with moderating the ATBPCS. HHS will also contact Indian Organizations in the planning of the session in order to ensure inclusion of all perspectives and issues.
9. Presentation protocol will ensure that the highest ranking official from each respective Tribe is given the opportunity to address the session first, followed by other elected officials, those designated by their elected official to represent their respective Indian Tribes and representatives of Indian/Tribal Organizations.
    i. Official letter from the Indian Tribe designating a representative must be presented to IGA before the session begins.

B. Performance Budget Formulation: HHS IGA will ensure the active participation of Indian Tribes and Indian Organizations in the formulation and throughout the HHS performance budget request as it pertains to Indian Tribes to the greatest extent practicable and permitted by law.

C. Budget Information Disclosure: HHS provides Indian Tribes the HHS budget related information on an annual basis: appropriations, allocation, expenditures, and funding levels for programs, services, functions, and activities.

12. TRIBAL CONSULTATION PERFORMANCE AND ACCOUNTABILITY

HHS and its Divisions will measure and report results and outcomes of their Tribal consultation performance to fulfill the government-to-government relationship with Indian Tribes.

Parts of the HHS mission and performance objectives are designed to address the health and well-being of AI/ANs by providing for effective health and human services and by fostering strong, sustained advances in the sciences underlying medicine, public health and social services.

The Divisions shall utilize the Tribal Consultation Policy to address HHS's mission and performance objectives with respect to AI/ANs. HHS and its Divisions will follow the goals and objectives of the seated Secretary and Administration.

Divisions and Indian Tribes will also promote a collaborative atmosphere to gather, share, and collect data and other information to demonstrate the effective use of Federal resources in a manner that is consistent with OMB performance measures and requirements. Divisions shall consult, to the greatest extent practicable and permitted by law, with Indian Tribes before taking actions that substantially affect Indian Tribes, including regulatory practices on Federal matters and unfunded mandates.

13. EVALUATION, RECORDING OF MEETINGS AND REPORTING

The consultation process and activities conducted within the policy should result in a meaningful outcome for the Department and for the affected Indian Tribes. To effectively evaluate the results of a particular consultation activity and the Department's ability to incorporate Indian Tribes' consultation input, the Department should measure, on an annual basis, the level of satisfaction of the Indian Tribes.

1. Divisions should develop and utilize appropriate evaluation measures to assess Indian Tribes' responses to Department consultation conducted during a specific period to determine if the intended purpose of the consultation was achieved and to receive recommendations to improve the consultation process.
    a. The Divisions will maintain a record of the consultation, evaluate whether the intended results were achieved, and report back to the affected Indian tribe(s) on the status or outcome, including, but not limited to, the annual sessions conducted below.

2. At a minimum, HHS Regional Directors will conduct an Annual Regional Tribal Consultation to consult with Indian Tribes.

    a. These sessions shall provide an opportunity to receive the Indian Tribe's priorities for budget, regulation, legislation, and other policy matters.
    b. Consultation Sessions shall include evaluation components for receipt of verbal and written comments from participating Indian Tribes, HHS Divisions, and other invited participants to obtain immediate feedback on the consultation process for the session conducted.
    c. The Divisions and the Regional Directors will report at each regional Tribal consultation session regarding what substantive and procedural actions were

taken as a result of the previous Tribal consultation session and describe how HHS addressed the consultation evaluation comments provided received by participants.

d. All national and regional consultation meetings and recommended actions shall be formally recorded and made available to Indian Tribes.
e. Once the consultation process is complete, and any policy decision is finalized, all recommended follow-up actions adopted shall be implemented and tracked by the appropriate Regions and/or Divisions and reported to the Indian Tribes in the IGA Annual Tribal Consultation Report.
f. Unless otherwise specified, the IGA Annual Consultation Report shall provide an annual reporting mechanism for this purpose and all HHS Divisions are required to participate in providing information for this report.

3. IGA will seek Tribal feedback to assist in measuring and evaluating the implementation and effectiveness of this Policy. IGA will assess the Department Tribal Consultation Policy on an ongoing basis and utilize comments from Indian Tribes and Federal participants to determine whether amendment to the Policy may be required. If amendment is needed, IGA will convene a Tribal-Federal workgroup.

4. Divisions are required to submit to IGA their fiscal year Tribal consultation information within 90 calendar days from the end of the fiscal year. IGA shall compile the Division submissions, and publish and distribute the information to the Indian Tribes within 60 calendar days from receipt of the Division reports. The IGA, Regional Directors and Divisions shall also report the Department's views on the level of attendance and response from Tribal leaders during the Annual Tribal Budget and Policy Consultation Session and the Annual Regional Tribal Consultation Sessions, including evaluative comments, and provide advice and recommendations regarding the Tribal consultation process. The IGA shall post on the HHS website, the IGA Annual Tribal Consultation Report, including the evaluation results.

14. **CONFLICT RESOLUTION**

The intent of this policy is to promote partnership with Indian Tribes that enhance the Department's ability to address issues, needs and problem resolution. Agencies shall consult with Indian Tribes to establish a clearly defined conflict resolution process under which Indian Tribes bring forward concerns which have a substantial direct effect. However, Indian Tribes and HHS may not always agree and inherent in the government-to-government relationship, Indian Tribes may elevate an issue of importance to a higher or separate decision-making authority.

Nothing in the Policy creates a right of action against the Department for failure to comply with this Policy.

15. **TRIBAL WAIVER**

Divisions shall review and streamline the processes under which Indian Tribe may apply for waivers of statutory, regulatory, policy, or procedural requirements. Each Division shall, to the extent practicable and permitted by law, consider any application by an

Indian Tribe for a waiver with a general view toward increasing opportunities for utilizing flexible approaches at the Indian Tribal level when the proposed waiver is consistent with the applicable Federal policy objectives and is otherwise appropriate. Each Division shall, to the extent practicable and permitted by law, render a decision upon a complete application for a waiver within 120 calendar days of receipt, or as otherwise provided by law or regulation. If the application for waiver is not granted, the Division shall provide the applicant with timely written notice of the decision and the reasons therefore. Waiver requests for statutory or regulatory requirements apply only to statutory or regulatory requirements that are discretionary and subject to waiver by the Division.

16. **EFFECTIVE DATE**

This policy is effective on the date of the signature by the Secretary of Health and Human Services.

This policy replaces the Tribal Consultation Policy signed on February 1, 2008, and it applies to all Operating Divisions and Staff Divisions. Operating Divisions shall complete necessary revisions to their existing Division consultation policy/plan to conform to the revised Department Tribal Consultation Policy. Operating Divisions without a consultation policy shall utilize the guidance of the OS policy until the development of their respective policy.

17. **DEFINITIONS**

1. **Agency –** Any authority of the United States that is an "agency" under 44 USC 3502(1) other than those considered to be independent regulatory agencies, as defined in 44 USC 3502 (5).

2. **Communication –** The exchange of ideas, messages, or information, by speech, signals, writing, or other means.

3. **Consultation –** An enhanced form of communication, which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process, which results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues.

4. **Coordination and Collaboration –** Working and communicating together in a meaningful government-to-government effort to create a positive outcome.

5. **Critical Events –** Planned or an unplanned event that has or may have a substantial impact on Indian Tribe(s), e.g., issues, polices, or budgets which may come from any level within HHS.

6. **Deliberative Process Privilege –** Is a privilege exempting the government from disclosure of government agency materials containing opinions, recommendations, and other communications that are part of the decision-making process within the agency.

7. **Executive Order –** An order issued by the Government's executive on the basis of authority specifically granted to the executive branch (as by the U.S. Constitution or a Congressional Act).

8. **Federally Recognized Tribal governments –** Indian Tribes with whom the Federal Government maintains an official government-to-government relationship; usually established by a Federal treaty, statute, executive order, court order, or a Federal Administrative Action. The Bureau of Indian Affairs (BIA) maintains and regularly publishes the list of Federally recognized Indian Tribes.

9. **HHS Tribal Liaisons –** HHS staff designated by the head of an HHS Division that are knowledgeable about the Division's programs and budgets, and have ready access to senior HHS Division leadership, and are empowered to speak on behalf of that Division for AI/AN/NA programs, services, issues, and concerns.

10. **Indian –** Indian means a person who is a member of an Indian tribe as defined in 25 U.S.C. 479a. Throughout this policy, Indian is synonymous with American Indian/Alaska Native.

11. **Indian Organizations:** 1). Those Federally recognized tribally constituted entities that have been designated by their governing body to facilitate DHHS communications and consultation activities. 2). Any regional or national organizations whose board is comprised of Federally recognized Tribes and elected/appointed Tribal leaders. The government does not participate in government-to-government consultation with these entities; rather these organizations represent the interests of Tribes when authorized by those Tribes.

12. **Indian Tribe –** an Indian or Alaska Native tribe, band, nation, pueblo, village, or community that the Secretary of the Interior acknowledges to exist as an Indian tribe pursuant to the Federally Recognized Indian Tribe List Act of 1994, 25 U.S.C. 479a."

13. **Intradepartmental Council on Native American Affairs (ICNAA) –** Authorized by the Native American Programs Act of 1974 (NAPA), as amended. The ICNAA serves primarily to perform functions and develop recommendations for short, intermediate, or long-term solutions to improve AI/AN/NA policies and programs as well as provide recommendations on how HHS should be organized to administer services to the AI/AN/NA population.

14. **Joint Tribal/Federal Workgroups and or/Task Forces –** A group composed of individuals who are elected Tribal officials, appointed by Federally recognized Tribal governments and/or Federal agencies to represent their interests while working on a particular policy, practice, issue and/or concern.

15. **Native American (NA) –** Broadly describes the people considered indigenous to North America.

16. **Policies with Tribal Implications –** Refers to regulations, statutes, legislation, and other policy statements or actions that have substantial direct effects on one

or more Indian Tribes, on the relationship between the Federal Government and Indian Tribes, or on the distribution of power and responsibilities between the Federal Government and Indian Tribes.

17. **Self Government –** Government in which the people who are most directly affected by the decisions make decisions.

18. **Sovereignty –** The ultimate source of political power from which all specific political powers are derived.

19. **Substantial Direct Compliance Costs –** Those costs incurred directly from implementation of changes necessary to meet the requirements of a Federal regulation. Because of the large variation in Tribes, “substantial costs” is also variable by Indian Tribe. Each Indian Tribe and the Secretary shall mutually determine the level of costs that represent “substantial costs” in the context of the Indian Tribe’s resource base.

20. **To the Extent Practicable and Permitted by Law –** Refers to situations where the opportunity for consultation is limited because of constraints of time, budget, legal authority, etc.

21. **Treaty –** A legally binding and written agreement that affirms the government-to-government relationship between two or more nations.

22. **Tribal Government –** An American Indian or Alaska Native Tribe, Band, Nation, Pueblo, Village or Community that the Secretary of the Interior acknowledges to exist as an Indian Tribe pursuant to the Federally Recognized Indian Tribe List Act of 1994, 25 USC 479a.

23. **Tribal Officials –** Elected or duly appointed officials of Indian Tribes or authorized inter-Tribal organizations.

24. **Tribal Organization –** The recognized governing body of any Indian tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities: Provided, That in any case where a contract is let or grant made to an organization to perform services benefiting more than one Indian tribe, the approval of each such Indian tribe shall be a prerequisite to the letting or making of such contract or grant.

25. **Tribal Resolution –** A formal expression of the opinion or will of an official Tribal governing body which is adopted by vote of the Tribal governing body.

26. **Tribal Self–Governance –** The governmental actions of Tribes exercising self-government and self-determination.

18. **ACRONYMS**

AI/AN:	American Indian/Alaska Native
AI/AN/NA:	American Indian/Alaska Native/Native American
ASFR:	Assistant Secretary for Finance and Resources
BIA:	Bureau of Indian Affairs
Division:	Staff Division and/or Operating Division
EO:	Executive Order
FACA:	Federal Advisory Committee Act
FR:	Federal Register
HHS:	U.S. Department of Health and Human Services
ICNAA:	Intradepartmental Council on Native American Affairs
IGA:	Office of Intergovernmental Affairs
IOS:	Immediate Office of the Secretary
NPRM:	Notice of Proposed Rule Making
OMB:	Office of Management and Budget
OS:	Office of the Secretary
U.S.:	United States
U.S.C.:	United States Code

/S/ Kathleen Sebelius **December 14, 2010**

Secretary

U.S. Department of Health and Human Services

ADDENDUM 1

Establishing Joint Tribal/Federal Workgroups and/or Tasks Forces:
Although the special "Tribal-Federal" relationship is based in part on the government-to-government relationship it is frequently necessary for HHS to establish Joint Tribal/Federal Workgroups and/or Task Forces to complete work needed to develop new policies, practices, issues, and/or concerns and/or modify existing policies, practices, issues, and/or concerns. These Joint Tribal/Federal Workgroups and/or Task Forces do not take the place of Tribal consultation, but offer an enhancement by gathering individuals with extensive knowledge of a particular policy, practice, issue and/or concern to work collaboratively and offer recommendations for consideration by Federally recognized Indian Tribes and Federal agencies. The subsequent work products and/or outcomes developed by the Joint Tribal/Federal Workgroup and/or Task Forces will be handled in accordance with this policy. These Workgroups will be Federal Advisory Committee Act (FACA) compliant unless exempt.

1. Meeting Notices: The purpose, preliminary charge, time frame, and other specific tasks shall be clearly identified in the notice. All meetings should be open and widely publicized ideally through IGA or the Division initiating the policy.
2. Workgroups: membership should be selected based on the responses received from prospective HHS Regions/Indian Health Service Areas as a result of the

notice, and if possible, should represent a cross-section of affected parties. HHS staff may serve in a technical advisory capacity.

A. Participation:

1. Membership Notices: HHS shall seek nominations from Indian Tribes to participate in taskforces and/or workgroups. The Secretary shall select workgroup members that represent various regions and/or views of Indian Country. Membership of these workgroups shall be in compliance with FACA unless the workgroup is exempt
2. Appointment of Alternates: Each primary representative may appoint an alternate by written notification. In cases where an elected Tribal Leader (primary representative) appoints an alternate who is not an elected official, and the primary member can not attend a workgroup meeting, the alternate is permitted to represent the primary member and will have the same voting rights as the primary member.
3. Attendance at Meetings: Workgroup members must make a good faith effort to attend all meetings. Other individuals may accompany workgroup members, as that member believes is appropriate to represent his/her interest, however FACA requirements will be adhered to at meetings unless exempt

B. Workgroup Protocols: The workgroup may establish protocols to govern the meetings. Such protocols will include, but are not limited to the following:

1. Selection of workgroup co-chairs, if applicable
2. Role of workgroup members
3. Process for decision-making (consensus based or otherwise)
4. Developing a Workgroup Charge. Prior to the workgroup formulation, the HHS will develop an initial workgroup charge in enough detail to define the policy concept. The workgroup may develop recommendations for the final workgroup charge for the approval of the HHS Secretary, the IGA Director or the Division head.

C. Process for Workgroup Final Products: Once a final draft of the work product has been created by the workgroup the following process will be used to facilitate Tribal consultation on the draft work product:

1. Upon completion, the draft documents will be distributed informally to Indian Tribes and Indian Organizations for review and comment and to allow for maximum possible informal review.
2. Comments will be returned to the workgroup, which will meet in a timely manner to discuss the comments and determine the next course of action.
3. At the point that the proposed draft policy is considered to be substantially complete as written, the workgroup will forward the draft document to the HHS Secretary as final recommendation for consideration.
4. The workgroup will also recognize any contrary comment(s) in its final report and explain the reasoning for not accepting the comment(s).
5. If it is determined that the policy should be rewritten, the workgroup will rewrite and begin informal consultation again at the initial step above.

6. If the proposed policy is generally acceptable to the HHS Secretary, final processing of the policy by the workgroup will be accomplished.

D. Recommendations and Policy Implementation: All final recommendations made by the workgroup should be presented to the Secretary. Before any final policy decisions are adopted within HHS, the proposed policy shall be widely publicized and circulated for review and comment to Indian Tribes, Indian Organizations, and within HHS. Once the consultation process is complete and a proposed policy is approved and issued, the final policy shall be broadly distributed to all Indian Tribes.

APPENDIX III

SECRETARY'S TRIBAL ADVISORY COMMITTEE

Background

The United States has a unique legal and political relationship with Indian tribal governments, established through and confirmed by the Constitution of the United States, treaties, statutes, executive orders, and judicial decisions. In recognition of that special relationship, pursuant to Executive Order 13175 of November 6, 2000, executive departments and agencies are charged with engaging in regular and meaningful consultation and collaboration with tribal officials in the development of Federal policies that have tribal implications, and are responsible for strengthening the government-to-government relationship between the United States and Indian tribes.

The Department of Health and Human Services (HHS) has taken its responsibility to comply with Executive Order 13175 very seriously over the past decade, and on February 4, 2010, in compliance with President Obama's Memorandum for the Heads of Executive Departments and Agencies, signed on November 5th, 2009, HHS proposed a set of initial activities to step up the Department's efforts to improve services, outreach, and consultation efforts. The establishment of the Secretary's Tribal Advisory Committee (STAC), one key piece of this plan, will bring the work of HHS's reform and improvement efforts to a new level.

Purpose and Function

The Secretary's Tribal Advisory Committee signals a new level of attention to Government-to-Government relationship between HHS and Indian Tribal Governments.

The STAC's primary purpose is to seek consensus, exchange views, share information, provide advice and/or recommendations; or facilitate any other interaction related to intergovernmental responsibilities or administration of HHS programs, including those that arise explicitly or implicitly under statute, regulation or Executive Order. This purpose will be accomplished through forums, meetings and conversations between Federal officials and elected Tribal leaders in their official capacity (or their designated employees or national associations with authority to act on their behalf).

The purview of the STAC covers but is not limited to the following core functions:

1. Identify evolving issues and barriers to access, coverage and delivery of services to AI/ANs, related to HHS programs;
2. Propose clarifications and other recommendations and solutions to address issues raised at Tribal, regional and national levels;
3. Serve as a forum for Tribes and HHS to discuss these issues and proposals for changes to HHS regulations, policies and procedures;
4. Identify priorities and provide advice on appropriate strategies for Tribal consultation on issues at the Tribal, regional and/or national levels;
5. Ensure that pertinent issues are brought to the attention of Indian Tribes in a timely manner, so that timely Tribal feedback can be obtained;
6. Coordinate with HHS Regional Offices' and Operating Divisions on Tribal consultation initiatives.

Committee Composition

The STAC will be comprised of seventeen positions to be filled by voluntary representatives: one delegate (and one alternate) from each of the twelve Indian Health Service (IHS) areas and one delegate (and one alternate) for five National At-Large Tribal Member (NALM) positions.

HHS understands and supports the role of national Tribal organizations and the work they do on behalf of Tribal Governments. There are many national Tribal organizations that are not physically based in Washington, DC, and, therefore, are often left out of DC-based advisory opportunities. In order to rectify this long-standing challenge, in accordance with the Federal Advisory Committee Act (FACA) exemption of the Unfunded Mandates Reform Act (UMRA), HHS has incorporated the "National At Large Member (NALM)" positions as members of the STAC, to provide specific representation for the regional and national concerns of tribal governments. As described below under Selection Process, all NALM members must either be elected Tribal officials, acting in their official capacity as elected officials of their Tribe, or be designated by an elected Tribal official, in that official's elected capacity, with authority to act on behalf of the Tribal official.

The Secretary sent a letter to Tribal leaders requesting nominations for STAC delegate and alternate from Tribes located in each of the twelve Indian Health Service (IHS) Areas for the Area positions and as well as nominations for five NALM delegate and alternate positions.

Primary committee members must make a good faith effort to attend all meetings via teleconference or in person and may be accompanied by a technical advisor as outlined below. Each committee member will have an alternate that has been selected for their specific area and in the event that the Primary committee member cannot attend a meeting the alternate workgroup member will be notified. Such alternate shall have the full rights as designated in the letter by the delegate.

Selection Process

The names of each STAC delegate and alternate from each of the twelve Area Offices of the IHS are to be submitted to the Office of Intergovernmental Affairs (IGA) in an official letter from the Tribe. The Chief of Staff and the Director of IGA will be responsible for selecting and finalizing the body of members.

Area Representatives:

Area Representatives should be an elected official or designated representative that is qualified to represent the views of the Indian Tribes in the respective area for which they are being nominated. Nominations will be considered for selection in the priority order listed below. In the event that there is more than one nomination in the priority list, individuals whom had a letter of support from regional tribal organizations will be taken into consideration when selecting the primary and alternate delegates.

1. Tribal President/Chairperson/Governor
2. Tribal Vice-President/Vice-Chairperson/Lt. Governor
3. Elected or Appointed Tribal Official
4. Designated Tribal Official

National At Large Members

In order to achieve the broadest coverage of HHS-related national perspectives and views, the STAC will include five positions for national at-large members (NALMs). A NALM should be an elected official or designated representative that is qualified to represent the views of tribes on a national, collective perspective, including but not limited to such views of groups like National Congress of American Indians, National Indian Health Board, Tribal Self Governance Advisory Committee, Direct Service Tribes Advisory Committee, National Indian Child Welfare Association, National Indian Headstart Director's Association and the National Tribal Environmental Council.

Nominations will be considered for selection in the priority order listed below. In the event that there is more than one nomination in the priority list, individuals whom had a letter of support from tribal organizations will be taken into consideration when selecting the primary and alternate delegates.

1. Tribal President/Chairperson/Governor
2. Tribal Vice-President/Vice-Chairperson/Lt. Governor
3. Elected or Appointed Tribal Official
4. Designated Tribal Official

Period of Service:

Terms for the STAC will be two calendar years. Terms will be staggered, with a lottery method used to assign one-year terms to half the Area members and two of the NALMs initially appointed to the STAC (with their first terms expiring on December 31, 2011) and two-year terms to the remaining half of the Area members and three of the NALMs (with their first terms expiring on December 31, 2012). A member may serve successive, consecutive terms if nominated again when their term expires.

Vacancy: When a vacancy occurs, IGA will notify Indian Tribes in the respective area and ask them to nominate a replacement.

Removal: STAC members (either delegate or alternate) are expected to make a good faith effort to participate in all meetings and telephone conference calls. If a STAC delegate does not participate in a meeting, in-person or by telephone, on three successive occasions, (or an STAC

alternate does not participate in a meeting, in-person or by telephone, for which he/she has agreed in advance to participate in place of the delegate) on three successive occasions, IGA will notify Indian Tribes in the respective area and ask them to nominate a replacement.

Interim Representative: When there is a vacancy in a delegate position (due to removal of for other reasons) for which an alternate is currently serving, IGA will notify the alternate and request that the alternate perform the duties of the delegate. The criteria and process for selecting a replacement following a vacancy or removal will follow the Selection Process described above. A replacement delegate or alternate will serve the remainder of the unexpired term of the original member and if nominated again may serve successive, consecutive terms.

A copy of this notification and any response from the alternate to this request will be forwarded to the respective Area Tribes and a notice will be give to all Tribes for a NALM for nominations of a replacement.

Meetings:

Depending upon availability of funds, it is anticipated the STAC will convene up to three face-to-face meetings on a fiscal year basis. Conference calls will be held as needed.

STAC meetings serve the Purposes and Functions described above and in § 204(b)(2) of UMRA for STAC Tribal delegates and alternates and designated HHS officials to exchange views, information, and advice. Under certain circumstances, the delegate, alternate, or both for an Area or NALM position may participate in a meeting or conference call, in-person or by telephone. When the delegate is the elected officer of a Tribal government, and the alternate is a designated employee or national association with authority to act on behalf of the elected officer, and they are present for the same meeting or call, the delegate may designate, in writing, the alternate to participate on the delegate's behalf at the meeting or call, and the delegate will yield his or her participation to the alternate until the delegate wishes to resume participation at the meeting or call. When the delegate and alternate are both elected Tribal government officers or have both been designated by an elected officer of a Tribal government to act on behalf of the officer, they may both participate in the same meeting or call. In the instance that both the primary and alternate attend the meeting, HHS will only provide funding for the primary representative.

If both the primary and the alternate for a particular Area or NALM position are participating in the same meeting or call, only one will be counted for a quorum and voting purposes. The primary and alternate may agree which of them will express a view for consensus or vote on particular issues. If they do not agree, then the delegate's view or vote will be counted.

IGA will provide appropriate advance notice to STAC delegates and alternates of in-person meetings and conference calls.

A quorum consisting of a majority of the total number of Area and NALM positions (9 of 17, if all such positions are filled by a delegate or alternate, present in-person and by telephone, will be necessary for formal decisions and actions by the STAC. (Informational sessions may occur in the absence of a quorum.) To the extent possible, such STAC decisions and actions will be taken by a consensus of Tribal Area and NALM members. To resolve differences where consensus cannot be reached, a vote may be taken by simple majority of the positions

represented, in-person and by telephone (a quorum being present) or the Chair or Co-Chair may authorize a subsequent polling of the positions.

The meetings will be limited to only official representatives of the committee. Tribal delegates will be allowed to bring one-technical advisor to the meeting to assist them with their duties and responsibilities as a member of the STAC. The advisor's role is limited to assisting the member, and the advisor cannot participate in the meetings of the STAC, unless the advisor has been designated by the elected Tribal official to act on behalf of the official at the meeting.

HHS has four Tribal Advisory Committees(TAC) which are established at the HHS Division level and currently exist at the Centers for Disease Control, Centers for Medicaid and Medicare, Substance Abuse Mental Health Service Administration and the Health Research Advisory Committee. Each TAC will be required to provide an official update to the STAC on an annual basis. Each TAC will receive an official invitation to present to the STAC. At which time they will have one representative present to the STAC.

HHS representatives determined by the Secretary or her designee will be expected to attend all meetings of the STAC. In the event that the designated HHS representatives are not able to attend the meeting, the next highest ranking official will be designated to attend in their absence. The HHS representative will be allowed to bring one-technical advisor to the meeting to assist them with their duties and responsibilities as an advisor to the STAC. The advisor must be either a full-time or permanent part-time officer or employee of the federal government.

HHS anticipates that appropriate representatives from the following HHS components will be actively involved, regularly attend STAC meetings, and otherwise provide necessary assistance to the STAC in fulfilling its mission.

1. Chief of Staff
2. Director, Office of Intergovernmental Affairs
3. Assistant Secretary, Administration for Children and Families
4. Assistant Secretary, Administration on Aging
5. Assistant Secretary Health, Office of Public Health and Science
6. Director, Centers for Disease Control and Prevention
7. Administrator, Centers for Medicaid and Medicare Services
8. Administrator, Health Resource Service Administration
9. Director, Indian Health Service
10. 0. Director, National Institutes of Health
11. 1. Administrator, Substance Abuse Mental Health Services Administration

Due to the complexity of programs and services HHS will work to ensure that subject matter technical experts are available when needed. As mentioned above the meetings will be limited to the official representatives and HHS will utilize the Interdepartmental Council on Native American Affairs (ICNAA) as a vehicle to report activities of the STAC and coordinate agenda's, activities and follow-up items of the STAC.

HHS Support: The Office of Intergovernmental Affairs will have the primary responsibility to coordinate and staff the STAC.

United States Department of Health and Human Services
Secretary's Tribal Advisory Committee
Tribal Members

IHS Area/HHS Region	DELEGATE Tribe or Organization	ALTERNATE Tribe or Organization
Aberdeen Area (Region 7-Kansas City) (Region 8-Denver)	***Robert Cournoyer*** Chairman Yankton Sioux Tribe P.O. Box 248 Marty, South Dakota 57361	***Tony Reider*** President Flandreau Santee Sioux Tribe P.O. Box 283 Flandreau, South Dakota 57028
Alaska Area (Region 10-Seattle)	**Vacant**	***Andy Tueber, Jr.*** Tribal Council Member Woody Island Tribal Council 4000 Ambassador Drive Anchorage, Alaska 99508
Albuquerque Area (Region 6-Dallas) (Region 8-Denver)	***Norman Cooeyate*** Governor Pueblo of Zuni P. O. Box 339 1203-B State Highway 53 Zuni, New Mexico 87327-0339	***Gary Hayes*** Chairman Elect The Ute Mountain Tribal Council PO Box JJ Towaoc, CO 81334
Bemidji Area (Region 5- Chicago)	***Cathy Abramson*** Tribal Council Representative Sault Ste. Marie Chippewa Indians 523 Ashum Street Sault Ste Marie, MI 49783	***Kathy Hughes*** Vice Chairwoman Oneida Tribe of Indians of Wisconsin P. O. Box 365 Oneida, Wisconsin 54155-0365
Billings Area (Region 8- Denver)	***L. Jace Killsback*** Tribal Council Representative Northern Cheyenne Tribe P. O. Box 128 Lame Deer, Montana 59043	***Cedric Black Eagle*** Chairman Crow Tribe Bacheeitche Avenue P.O. Box 159 Crow Agency, Montana 59022
California Area (Region 9- San Francisco)	***Arch Super*** Tribal Chairman Karuk Tribe Administration Office 64236 Second Avenue P.O. Box 1016 Happy Camp, California 96039	***Stacy Dixon*** Tribal Chairman Susanville Indian Rancheria 745 Joaquin Street Susanville, California 96130

IHS Area/HHS Region	DELEGATE Tribe or Organization	ALTERNATE Tribe or Organization
Nashville Area (Region 1- Boston) (Region 2- New York) (Region 3- Philadelphia) (Region 4- Atlanta) (Region 6-Kansas City)	***Buford L. Rolin*** Tribal Chairman Poarch Band of Creek Indians 5811 Jack Springs Road Atmore, Alabama 36502	***Cheryl Frye-Cromwell*** Tribal Council - Health Liaison Interim Tribal Health Manager Mashpee Wampanoag Tribe 483 Great Neck Road P.O. Box 1048 Mashpee, MA 02649
Navajo Area (Region 6- Dallas) (Region 8- Denver) (Region 9- San Francisco)	***Joe Shirley, Jr.*** President Navajo Nation Tribal Hill Drive Window Rock, AZ 86515	***Anslem Roanhorse, Jr.*** The Navajo Nation Navajo Division of Health, Window Rock Blvd – Administration Bldg. 2, Window Rock, AZ 86511
Oklahoma Area (Region 6- Dallas) (Region 7- Kansas City)	***Steven Ortiz*** Tribal Chairman Prairie Band of Potawatomi Nation 16281 Q Road P.O. Box 249 Mayetta, Kansas 66509	***Melanie Knight*** Secretary of State Cherokee Nation P.O. Box 948 Tahlequah, Oklahoma 74465-0948
Phoenix Area (Region 8- Denver) (Region 9- San Francisco)	***Herman G. Honanie*** Vice Chairman The Hopi Tribe P.O. Box 123 Kykotsmovi, Arizona 86039	***David Kwail*** Tribal Chairman Yavapai-Apache Nation 2400 W. Datsi Street Camp Verde, Arizona 86322
Portland Area (Region 10- Seattle)	***Cheryle A. Kennedy*** Tribal Council Chairwoman Confederated Tribes of the Grande Ronde Tribal Council 9615 Grand Ronde Road Grand Ronde, Oregon 97347	***Elizabeth Ann Lindroth*** Tribal Council Member Shoshone-Bannock Tribal Business Council Fort Hall Business Council P.O. Box 306 Fort Hall, Idaho 83203
Tucson Area (Region 9- San Francisco)	***Chester Antone*** Council Member, Tohono O'odham Nation Legislative Council's Health and Human Service Committee P. O. Box 837 Sells, AZ 85634	Pascua Yaqui Tribe

National At Large Members	DELEGATE	ALTERNATE
Five (5) Delegates with two (2) Alternates	***Jefferson Keel, Lt. Governor*** Lt. Governor of the Chickasaw Nation of Oklahoma P.O. Box 1548 Ada, Oklahoma 74821	***Gil Vigil*** Tribal Council Member Pueblo of Tesuque Route 42 Box 360-T Santa Fe, New Mexico 87506
	Reno Franklin Vice Chairman Kashia Band of Pomo Indians of Stewarts Point Rancheria 3535 Industrial Drive, Suite B-2 Santa Rosa, California 95403	
	Tex Hall Chairman Mandan, Hidatsa & Arikara Nation 404 Frontage Road, New Town. ND 58763	***Roberta Bisbee*** Tribal Council Member Nez Perce Tribal Council PO Box 305 Lapwai, ID 83540
	Ken Lucero Tribal Council Representative Pueblo of Zia 2401 12th street NW Albuquerque, NM 87104	
	Robert McGhee Tribal Council Representative and Treasurer Poarch Band of Creek Indians 5811 Jack Springs Road Atmore, Alabama 36502	

APPENDIX IV

FREQUENTLY USED ACRONYMS

4 A's	Alaskan Aids Assistance Association
AAIHS	Albuquerque Area Indian Health Service
AATCHB	Aberdeen Area Tribal Chairmen's Health Board
ACA	Affordable Care Act
ACF	Administration for Children and Families
ACLSU	Acoma, Canoncito, and Laguna Service Unit
ACTS	Automated Collection and Tracking System
ACYF	Administration on Children, Youth and Families
ADA	American Diabetes Association
ADD	Administration on Developmental Disabilities
AETC	AIDS Education and Training Centers
AFA	Annual Funding Agreement (IHS)
AFCARS	Adoption and Foster Care Analysis and Reporting System
AFDC	Aid to Families with Dependent Children
AFI	Assets for Independence
AHCCCS	Arizona Health Care Cost Containment System
AHEC	Area Health Education Center
AHRQ	Agency for Healthcare Research and Quality
AI/AN	American Indian and Alaska Native
AIC	American Indian Council
AIDS	Acquired Immunodeficiency Syndrome
AIP	Arctic Investigations Program
AIR	All-Inclusive-Rate
ANA	Administration for Native Americans
ANTHC	Alaska Native Tribal Health Consortium
APD	Advance Planning Document
ARRA	American Recovery and Reinvestment Act of 2009
ASPR	Assistant Secretary for Preparedness and Response
ASTHO	Association of State and Territorial Health Officers
ATSDR	Agency for Toxic Substances and Disease Registry Agency for Toxic Substances and Disease Registries
BHPr	Bureau of Health Professions
BIA	Bureau of Indian Affairs (DOI)
BPHC	Bureau of Primary Health Care

CAB	Capacity Building Assistance
CAO	California Area Office (IHS)
CARF	Commission on Accreditation of Rehabilitation Facilities
CATAC	California Area Tribal Advisory Committee
CB	Children's Bureau
CBO	Community-Based Organization
CBRN	Chemical, Biological, Radiological, and Nuclear
CCDF	Child Care and Development Fund
CDA	Child Development Associate
	Coeur d'Alene Tribe
CDC	Centers for Disease Control and Prevention
CDIB	Certificate of Degree of Indian Blood
CEO	Chief Executive Officers
CFCIP	Chafee Foster Care Independence Program
CFDA	Catalog of Federal Domestic Assistance
CHA	Community Health Aide
CHC	Community Health Center
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009
CHP	Community Health Practitioners
CHR	Community Health Representative (IHS)
CHS	Contract Health Services
CHSDA	Contract Health Services Delivery Area
CLASS	Classroom Assessment Scoring System
CME	Continuing Medical Education
CMS	Centers for Medicare & Medicaid Services
COE	Center of Excellence
CPPW	Communities Putting People to Work
CRCCP	Colorectal Cancer Control Program
CRCS	Comprehensive Risk Counseling and Services
CRIHB	California Regional Indian Health Board
	California Rural Indian Health Board
CSBG	Community Services Block Grant
CSC	Contract Support Costs (IHS)
CSE	Child Support Enforcement
CSPS	Comprehensive STD Prevention Services
CTR	Counseling, Testing and Referral
DASH	Division of Adolescent and School Health
DD	Developmental Disabilities
DEA	Drug Enforcement Administration
DEHS	Division of Environmental Health Services (IHS)
DETS	Diabetes Education in Tribal Schools
DFS	Division of Federal Systems
DHS	Department of Health Services
DMCHO	Division of Medicaid and Children's Health Operations
DMHPO	Division of Medicare Health Plan Operations
DOH	Department of Health
DOJ	Department of Justice
DP	Division of Policy

DPRE	Division of Planning, Research, and Evaluation
DSA	Division of State Assistance
DSHS	Department of Social and Health Services
DSLS	Division of Student Loans and Scholarships
DSTS	Division of State and Tribal Systems
DTTM	Division of Tribal TANF Management
DVPI	Domestic Violence Prevention Initiative (IHS)
EBI	Evidence-based Behavioral Intervention
ECE	Early Childhood Education
EHR	Electronic Health Record
EHS	Early Head Start
EIS	Early Intervention Services
	Epidemiologic Intelligence Officer
EMS	Emergency Medical Service
EMSC	Emergency Medical Services for Children
EMTALA	Emergency Medical Treatment and Active Labor Act
ENIPC	Eight Northern Indian Pueblo Council
EPA	U.S. Environmental Protection Agency
ESRD	End Stage Renal Disease
ETV	Education and Training Vouchers
EWIDS	Early Warning Infectious Disease Surveillance
FACA	Federal Advisory Committee Acct
FASD	Fetal Alcohol Spectrum Disorders
FBI	Federal Bureau of Investigation
FEHB	Federal Employees Health Benefits
FEMA	Federal Emergency Management Agency
FFS	Fee-for-Service
FMAP	Federal Medical Assistance Percentage
FQHC	Federally Qualified Health Center
FVPSA	Family Violence Prevention and Services Act Program
FY	Fiscal Year
FYSB	Family and Youth Services Bureau
GPRA	Government Performance and Results Act
GPTCHB	Great Plains Tribal Chairmen's Health Board
GYT	Get Yourself Talking
HAIC	Heart of America Indian Center
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIT	Health Information Technology
HITECH	Health Information Technology for Economic and Clinical Health
HIV	Human Immunodeficiency Virus
HPDP	Health Promotion and Disease Prevention
HPP	Hospital Preparedness Program
HPSA	Health Profession Shortage Area
HRAC	Health Research Advisory Council
HRSA	Health Resources and Services Administration
HUD	U.S. Department of Housing and Urban Development

I/T/U	Indian Health Service/Tribal/Urban Programs
IAA	Inter AIDS Association
	Inter-Agency Agreement
ICNAA	Intradepartmental Council on Native American Affairs
IDA	Individual Development Account
IFSP	Individualized Family Services Plan
IGA	Office of Intergovernmental Affairs
IHCIA	Indian Health Care Improvement Act
IHS	Indian Health Service
IJ	Immediate Jeopardy
IORA	Immediate Office of the Regional Administrator
IPA	Intergovernmental Personnel Agreement
IPC	Improving Patient Care Initiative (IHS)
IPP	Infertility Prevention Projects
IRS	Internal Revenue Service
ISDEAA	Indian Self-Determination and Education Assistance Act
IT	Information Technology
ITU	Indian, Tribal and Urban
JAN	Jicarilla Apache Nation
JVCP	Joint Venture Construction Program (IHS)
KHPA	Kansas Health Policy Authority
LCTHC	Lake County Tribal Health
LIHEAP	Low Income Home Energy Assistance Program
M&I	Maintenance & Improvement (IHS)
MAAC	Medical Assistance Advisory Council
MAC	Medicare Administrative Contractors
MAPPS	Media, Access, Pint of Purchase/Promotion, Price and Social Support Svc
MAT	Mescalero Apache Tribe
MCH	Maternal and Child Health
MCO	Managed Care Organizations
MCP	Mentoring Children of Prisoners
MFFP	Minority Faculty Fellowship Program
MIC	Missoula Indian Center
MLR	Medicare-Like Rates
MOU	Memorandum of Understanding
MSHS	Migrant and Seasonal Head Start
MSPI	Methamphetamine and Suicide Prevention Initiative (IHS)
MTS	Model Tribal System
MU	Meaningful Use
MUP	Medically Underserved Population
NAAAC	Native American Affairs Advisory Council
NAC	Native American Contract
NACA	Native Americans for Community Action
NACCHO	National Association of City and County Health Officials
NAFFA	Native Americans Fathers and Families Association

NAIHS	Navajo Area Indian Health Service
NAU	Northern Arizona University
NAVAHCS	Northern Arizona Veterans Affairs Health Care System
NBCCEDP	National Breast and Cervical Cancer Early Detection Program
NCBDDD	National Center on Birth Defects and Developmental Disabilities
NCCCP	National Comprehensive Cancer Control Program
NCCDPHP	National Center for Chronic Disease Prevention and Health Promotion
NCEH	National Center for Environmental Health
NCEZID	National Center for Emerging and Zoonotic Infectious Diseases
NCFY	National Clearinghouse on Families and Youth
NCHHSTP	National Center for HIV, Hepatitis, STD and Tuberculosis Prevention
NCHS	National Center for Health Statistics
NCIPC	National Center for Injury Prevention and Control
NCIRD	National Center for Immunization and Respiratory Diseases
NCRCCP	National Colorectal Cancer Control Program
NCUIH	National Council of Urban Indian Health
NDEP	National Diabetes Education Program
NDWP	Native Diabetes Wellness Program
NEW	Native Employment Works
NHANES	National Health and Nutrition Examination Survey
NHSC	National Health Service Corp
NHSFLC	National Head Start Family Literacy Center
NHSS	National Health Security Strategy
NIHB	National Indian Health Board
NIOSH	National Institute for Occupational Safety and Health
NMDOH	New Mexico Department of Health
NN	Navajo Nation
NPAIHB	Northwest Portland Area Indian Health Board
NPCR	The National Program of Cancer Registries
NPHPSP	National Public Health Performance Standards Program
NPIRS	National Patient Information and Reporting System
NRC	National Resource Center
NSRTC	New Sunrise Regional Treatment Center
NTEC	Northwest Tribal Epidemiology Center
NTTPN	National Tribal Tobacco Prevention Network
OCA	Oklahoma City Area (IHS)
OCC	Office of Child Care
OCH	Occupational Safety and Health
OCR	Office for Civil Rights
OCS	Office of Community Services
OCSE	Office of Child Support Enforcement
OEABS	Office of External Affairs and Beneficiary Services
OEHE	Office of Environmental Health and Engineering (IHS)
OFA	Office of Family Assistance
OHCA	Oklahoma Health Care Authority
OHS	Office of Head Start
OIT	Office of Information Technology (IHS)
OLDC	Online Data Collection
OMHD	Office of Minority Health and Health Disparities
OPDIV	Operating Divisions (of HHS)

ORHP	Office of Rural Health Policy
ORO	Office of Regional Operations
OS	Office of the Secretary
OSTLTS	Office for State, Tribal, Local and Territorial Support
OVW	Office of Violence Against Women
P&A	Protection and Advocacy Systems
PADD	Protection and Advocacy Systems – Developmental Disabilities
PAFAC	Portland Area Facilities Advisory Committee (IHS)
PAK	Physical Activity Kit
PBP	Prairie Band Potawatomi Nation
PCMH	Patient Centered Medical Home
PCV	Pneumococcal Conjugate Vaccine
PGO	Program and Grants Office
PHEP	Public Health Emergency Preparedness
PHHS	Preventive Health and Health Services
PHN	Public Health Nursing
PHR	Patient Health Record
PIR	Program Information Reports
PNS	Projects of National Significance
PPMNS	Planned Parenthood of Minnesota, North Dakota and South Dakota
PRAMS	Pregnancy Risk Assessment Monitoring System
PREP	Personal Responsibility Education Program
PSPC	Patient Safety and Clinical Pharmacy Services Collaborative
PYT	Pascua Yaqui Tribe
QI	Division of Quality Improvement
QTEM	Quarterly Tribal Epidemiology Meeting
REACH US	Racial and Ethnic Approaches to Community Health
RHY	Runaway and Homeless Youth Programs
RHYTTAC	Runaway and Homeless Youth Programs Training and Technical Assistance Contractor
RMSP	Rocky Mountain Spotted Fever
RO	Regional Office
RPMS	Resource and Patient Management System
SAH	Strategic Alliance for Health
SAMHSA	Substance Abuse and Mental Health Services Administration
SCF	Southcentral Foundation
SCTCA	Southern California Tribal Chairman's Association
SDS	Sanitation Deficiency System (IHS)
SEARHC	Southeast Alaska Regional Health Consortium
SEER	Surveillance, Epidemiology, and End Results
SFC	Sanitation Facilities Construction (IHS)
SIPI	Southwestern Indian Polytechnic Institute
SLT	Spirit Lake Tribe
SMD	State Medicaid Director
SORH	State Office of Rural Health
SPA	State Plan Amendments
SPARC	Strengthening Partnerships and Resources in Communities for Literacy

SPIEC	Southern Plains Inter Tribal Epicenter
SRS	Department of Social & Rehabilitation Services
SRST	Standing Rock Sioux Tribe
SSA	Social Security updates by a Social Security Administration
SSU	Sells Service Unit (IHS)
STAFFDIV	Staff Divisions
STAND	Students Against Negative Decisions
STD	Sexually Transmitted Disease Sexually Transmitted Infection
SUIT	Southern Ute Indian Tribe
SWAT	Students Working Against Tobacco
T/TA	Training and Technical Assistance
TA	Technical Assistance
TAG	Tribal Affairs Group
TANF	Temporary Assistance for Needy Families
TAO	Tucson Area Office (IHS)
TBH	TeleBehavioral Health (IHS)
TCAC	Tribal Consultation Advisory Committee
TCP	Tribal Consultation Policy
TCU	Tribal Colleges and Universities
TDM	Tribal Delegation Meeting (IHS)
TEC	Tribal Epidemiology Centers
TECC	Tribal Epi Center Consortium
THO	Tribal Health Organization
TIPS	Training, Information, and Practical Strategies
TLDC	IHS Tribal Leaders Diabetes Committee
TON	Tohono O'odham Nation
TriTAC	Tribal Technical Assistance Center
TTAG	Tribal Technical Advisory Group
TTANF	Tribal Temporary Assistance for Needy Families
TVIS	Title V Information System
UCEDD	University Centers for Excellence in Developmental Disabilities, Education, Research and Service
UDB	Unified Database Project
UDS	Uniform Data System
UFMS	United Financial Management System
VA	U.S. Department of Veterans Affairs
VIHSTA	Visionary and Innovative Health Sciences Training in Arizona
WISEWOMAN	Well-Integrated Screening/Evaluation for Women across the Nation
YRBS	Youth Risk Behavior Survey
YRTC	Youth Regional Treatment Center (IHS)
YST	Yankton Sioux Tribe